MEDICAL HISTORY

Name_____ Nickname _____Birthdate _____ Boy ☐Girl ☐

Brothers, Sisters _____

MEDICAL INFORMATION

Child's Physician _____ Phone # _____

Is your child taking any medications? Yes ☐ No ☐ Please list _____

_____

Does your child have any allergies or drug sensitivities? Yes ☐No ☐ Please describe _____

_____

Has your child ever been hospitalized, have surgery or been treated in an emergency department?

_____

Please check any of the following conditions for which your child has been treated

- ☐ Asthma
- ☐ Heart Murmur
- ☐ Bleeding Disorder/Anemia/sickle cell
- ☐ Heart Disorder/Defect
- ☐ Hepatitis
- ☐ AIDS/HIV Positive
- ☐ Liver/ Kidney Problems
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Nutritional Problems/GERD
- ☐ ADD/ADHD
- ☐ Autism/Autism spectrum disorder
- ☐ Behavioral, emotional problems
- ☐ Abuse or neglect
- ☐ Developmental disorders, learning problems/delays
- ☐ Speech/Hearing Problems
- ☐ Cerebral Palsy
- ☐ Cancer/Tumor/Chemotherapy/Radiation Therapy

Please describe any medical concerns your child has _____

DENTAL INFORMATION

Is there family history of cavities? _____

Please describe your main concern about your child's dental health _____

Has your child had a negative experience in the past with a dentist or physician? Please explain _____

_____

Former Dentist _____ Phone _____

Address _____

Date of last dental care _____ Date of last x-ray _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ☐Yes ☐No

Has your child experience a mouth or chin injury? ☐Yes ☐No

Does your child have speech problems? ☐Yes ☐No

Was your child bottle-fed? ☐Yes ☐No If so, how long? _____

Is fluoride taken in any form? ☐Yes ☐No

Other information about your child's dental health or previous treatment _____

_____

SIGNATURE _____Relationship with Child _____

Date _____