

Date _____ MEDICAL HISTORY

1. Is your child under care of a physician?..... Yes No
If yes, since when and why? _____
2. Name of physician _____
3. Is your child receiving any medication?..... Yes No
4. Is your child allergic to any drugs, such as penicillin?..... Yes No
5. Does your child have other allergies?..... Yes No
6. Has your child had any serious illness?..... Yes No
7. Has your child ever had surgery or been hospitalized?..... Yes No
8. Has your child had a history of any of the following?..... Yes No

Please check a response for each question:

- | | | |
|--|------------------------------|-----------------------------|
| Heart trouble, murmur, or surgery..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic fever or scarlet fever..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma, TC or lung problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| HIV infection or AIDS..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hemophilia or bleeding problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sickle cell anemia/blood disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hepatitis or liver problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Kidney infections..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cancer, tumor, leukemia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid or other glandular problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Latex or rubber allergy..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy, seizures, fainting..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cerebral palsy or development delay..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Vision problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Speech or hearing problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Emotional or psychological problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Congenital birth defects..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cleft lip or palate..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Malignant hyperthermia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other medical condition..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is the parent or patient pregnant?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

PURPOSE OF TODAY'S VISIT _____

- | | |
|--|--|
| 1. When and where was your child's last dental visit?
_____ | 7. Was/is your child weaned, and at what age: _____ |
| 2. What was the purpose of that visit? _____ | 8. When does your child brush his/her teeth?
<input type="checkbox"/> Upon rising <input type="checkbox"/> After eating any food
<input type="checkbox"/> Right after meals <input type="checkbox"/> Before going to bed |
| 3. Were any x-rays taken at your child's last dental visit? Yes <input type="checkbox"/> No <input type="checkbox"/> | 9. Do you assist/supervise your child's brushing?
Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Does your child have difficulty with cooperation?
Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 5. Was/is your child bottle fed? Yes No | |
| 6. Was/is your child breast fed? Yes No | |

MED ALERT	
Comments <input type="checkbox"/> (For Office use only)	

CONSENT: I understand that the information I have given is strictest confidence. Because my child is a minor, it is necessary to obtain consent from a legal guardian before any dental services can be rendered. I give my consent for such treatment, services, medication, behavior management to be rendered to my child for any dental / oral deficiency / abnormality or infection.

10. Does your child take fluoride supplements?

Yes No

11. Have any cavities been noted in the past? Yes No

12. Were any teeth (baby or permanent) removed by extraction? Yes No

13. Have there been any injuries to teeth, such as falls, blows, chips, etc.? Yes No

14. Has anyone in the family, including parents, had Orthodontics? Yes No

15. Has your child had a toothache recently? (If yes please explain)? Yes No

16. Do you expect your child to be cooperative?

Yes No

17. Does your child have siblings seen by us? Yes No