Medical History_____

Your child's overall health and any medications taken have an important connection with their dental treatment. Please be thorough when answering the following questions.

Child/Minor Name _____

Date_____

Child/Minor Physician Name_____ Last Physical Date_____

Is Child/Minor currently under a physician's care? YES ☐ NO ☐

Has Child/Minor ever been hospitalized? YES ☐ NO ☐

Has Child/Minor ever had any surgeries? YES ☐ NO ☐

Has Child/Minor ever had a serious head or neck injury? YES ☐ NO ☐

Is Child/Minor currently taking any medications, drugs, supplements or vitamins? YES ☐ NO ☐

If yes, please list _____

Is Child/Minor on a special diet? YES ☐ NO ☐

If yes, please describe _____

Does Child/Minor have any known allergies? YES ☐ NO ☐

If yes, please list_____

Does Child/Minor have or have had in the past any of the following? (please circle)

AIDS/HIV POSITIVE	DIABETES	LIVER DISEASE	THYROID PROBLEMS
ANAPHALAXIS	DIGESTIVE DISORDER	MEASLES	TONSILITIS
ANEMIA	EPILEPSY OR SEIZURES	MONONEUCLEOSIS	TUBERCULOSIS
ASTHMA	FREQUENT EAR INFECTIONS	MUMPS	TUMORS/GROWTHS
BLADDER PROBLEMS	HEARING IMPAIRMENT	NEUROLOGICAL PROBLEMS	VISUAL IMPAIRMENT
CANCER	HEART PROBLEMS	RESPIRATORY PROBLEMS	
CEREBRAL PALSY	HEPATITIS	RHEUMATIC FEVER	
CHICKEN POX	IMMUNOLOGICAL PROBLEMS	SCARLET FEVER	
CLEFT LIP OR PALATE	KIDNEY PROBLEMS	SICKLE CELL DISEASE	
COLD SORES/FEVER BLISTERS	LEARNING DISORDER	SINUS PROBLEMS	
CONVULSIONS	LEUKEMIA	SPINA BIFIDA	

Has the Child/Minor had any condition or illness NOT listed above? YES ☐ NO ☐

If yes, please explain _____

_____

_____

_____