Medical History Info for NEW Pediatric Patient

Child's Name _____

HEALTH PROVIDERS

Child's Physician/Pediatrician: _____ Phone#: _____

Mailing Address: _____ City: _____ State:_____ Zip: _____

MEDICAL HISTORY

General health: Is your child in good health? Y N Date of last physical exam:_____

Immunizations: Are your child's immunizations current? Y N

Antibiotics: Have you been told your child needs to take antibiotics before dental treatment? Y N Reason _____

Medical conditions: Does your child have history of, or conditions related to, any of the following? *(Check all that apply)*

General conditions

Asthma	Y	N
Cancer: Type _____	Y	N
Diabetes	Y	N
Gastrointestinal	Y	N
Heart /murmur	Y	N
Kidney/bladder	Y	N
Liver/Jaundice	Y	N
Rheumatic fever	Y	N
Seizures / Epilepsy	Y	N

Infectious

Hepatitis	Y	N
HIV infection (AIDS)	Y	N
Tuberculosis	Y	N
Persistent cough	Y	N
Bloody cough	Y	N

Developmental

Cerebral palsy	Y	N
Cleft lip/palate	Y	N
Feeding/Eating problems	Y	N
Growth/developmental delay	Y	N
Hearing loss	Y	N
Speech delay or impediment	Y	N
Neuromuscular, bones or Joint	Y	N

Hematological (Blood-related)

Anemia	Y	N
Excessive bleeding when cut	Y	N
Leukemia: Type _____	Y	N
Sickle cell disease	Y	N

Childhood diseases

Chicken pox	Y	N
Measles or Mumps	Y	N

Psychological/Behavioral

ADHD or Autism	Y	N
Anxiousness/Nervousness	Y	N
Behavior issues	Y	N
Emotional instability	Y	N
Learning disability	Y	N
Psychiatric disorder	Y	N

Substance use

Drug/Tobacco use	Y	N

Other

Fainting/headaches	Y	N
Earaches	Y	N
Sleep problems	Y	N

Other: _____

_____

If any boxes checked, please describe further:_____

_____

Medications:

Is your child currently taking any medications? Y N

PLEASE LIST MEDICATION, DOSE & REASON:

_____

_____

_____

Allergies:

Is your child allergic to any of the following: (If yes, please specify)

Medications or drugs?	Y	N	_____
Latex?	Y	N	_____
Foods?	Y	N	_____
Other?	Y	N	_____

Serious illnesses/Hospitalizations/Surgeries: Has your child ever been hospitalized or had any surgeries or operations? Y N

If yes, list dates, reason if general anesthesia used and if there were any complications:

_____

_____

Other: Is there anything else that you would like to tell the doctor about your child's dental or medical history? Y N If yes, please describe: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and is my responsibility to inform this office of any changes to my medical status.	**X**_____ _____ *Parent's Signature* *Date*	_____ _____ *Dentist Review* *Date*

RE-EVALUATION OF ORIGINAL MEDICAL HISTORY

At every visit, you will be asked to update your medical history. A complete medical history is essential and important for the safe and effective treatment. This form is completely confidential, and will be used only for dental and medical reasons.

Date	Changes?	If yes, what changes?	Signature	Reviewed by
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			