

MEDICAL HISTORY

The following information is essential for this office to provide dental care in a manner that is compatible with your child's general health. Your cooperation in providing accurate information is necessary to meet your child's dental needs safely and efficiently. Incorrect information can be dangerous to their health.

Name of Medical Doctor/Pediatrician: _____ Phone: _____
Address: _____
Date of Last Visit: _____ Reason For Last Visit: _____

Explain all "yes" answers below at #14

CIRCLE

- 1. Has your child been under a physician's care in the last 2 years, for other than routine care?YES NO
- 2. Has your child had any serious illness, operation or hospitalization in the past?YES NO
- 3. Is your child allergic to any drugs or medicines (novocain, penicillin, others)?YES NO
- 4. Is your child presently taking any drugs or medicines?YES NO
- 5. Has your child ever had hepatitis or yellow jaundice?YES NO
- 6. Is your child HIV positive?YES NO
- 7. Has your child ever been sick because of dental treatments?YES NO
- 8. Is your child a "bleeder" or have they had excessive bleeding following dental treatment?YES NO
- 9. Is your child having pain or discomfort at this time?YES NO
- 10. Has your child ever had a bad experience in the dental office?.....YES NO
- 11. Circle any condition your child has had or has at present:

Heart Trouble	Cancer	Diabetes
Heart Murmur	Thyroid Disease	Hemophilia
Heart Surgery	Kidney Trouble	Tuberculosis (TB)
High Blood Pressure	Liver Disease	Epilepsy or Seizures
Autism	Sinus Trouble	Fainting or Dizzy Spells
ADD	ADHD	Developmental Delay
Stroke	Asthma/Hay Fever	Anemia (Thin Blood)
Frequent Headaches	Bruise Easily	Sickle Cell Disease/Trait

- 12. Does your child have any disease, condition or problem not listed?YES NO
- 13. Is there anything else of importance that we should know about your child's health status?YES NO

Explain all "yes" answers below at #14

14. EXPLAIN ANY UNUSUAL MEDICAL PROBLEMS OR ANY ITEMS CIRCLED "YES" ABOVE:

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has any change in his/her health, or if his/her medications change, I will inform the dentist at the next appointment.

Parent/Guardian Signature: _____ Date: _____

Reviewed by Dr. Eberly: _____ Date: _____