

Child Medical History

CHILD'S FULL NAME _____ DATE OF BIRTH _____

PREFERRED NAME _____ PARENT/GURADIAN NAME _____

NAME OF MEDICAL PHYSICIAN _____

DOES CHILD HAVE OR HAVE THEY EVER HAD?

ABNORMAL BLEEDING	Y	N	HEART MURMUR	Y	N	TRAUMA TO MOUTH OR FACE	Y	N
ADHD	Y	N	DIABETES	Y	N	RHEUMATIC FEVER	Y	N
ASTHMA	Y	N	HEART DEFECT (CONGENITAL)	Y	N	SIEZURES/EPILEPSY	Y	N
CANCER	Y	N	HEPATITIS	Y	N	TUBERCULOSIS	Y	N
CEREBRAL PALSY	Y	N	HIV/AIDS	Y	N	FAINTING/DIZZINESS	Y	N
DEVELOPMENTAL DELAY	Y	N	PHYSICAL DISABILITY	Y	N	LOW BLOOD PRESSURE	Y	N
OTHER (PLEASE DESCRIBE) _____								

ALLERGIES

ANTIBOTICS (please list) _____	Y	N
LOCAL ANESTHETIC	Y	N
LATEX	Y	N
FOOD (please list) _____	Y	N
OTHER (please list) _____	Y	N

HAS CHILD BEEN HOSPITALIZED IN THE PAST TWO YEARS? Y N

DESCRIPTION _____

DOES THE CHILD CURRENTLY TAKE ANY MEDICATION(S)? Y N

PLEASE LIST _____

HABITS (PLEASE CIRCLE):

THUMB OR FINGER SUCKING	PACIFIER USE	NAIL BITING	LIP BITING	BITING HARD OBJECTS	TOOTH GRINDING	MOUTH BREATHING
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AUTHORIZATION AND REALEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the health of the patient. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such dental care to third party payers and/or health practitioners. I agree to notify the office of any health changes that may occur during the year.

SIGNATURE OF PARENT OR GUARDIAN

DATE