YOUR CHILD'S MEDICAL HISTORY

Your Child's name_____Nickname_____Date_____

Birth Date _____Medical Alert _____

Your Child's Physician: Name _____Telephone _____

Address _____City _____State_____ Zip_____

Is your child under the care of a physician? ……☐ Yes ☐ No
If yes, please describe_____

Is your child taking any medications? (prescription or over-the-counter)…… ☐ Yes ☐ No
If yes, please describe_____

Have you ever been told your child needs antibiotics or premeds before treatment? ……..☐ Yes ☐ No

Does your child have an allergic (or adverse) reaction to any medication or other substance?.. ☐ Yes ☐ No
If yes, please list_____

Are your child's immunizations current? ……☐ Yes ☐ No

List any Hospitalizations, Surgeries, Serious Illnesses	**When?**
_____	_____
_____	_____
_____	_____

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

AIDS/HIV positive…….☐ Yes ☐ No
Allergies or Hives……...☐ Yes ☐ No
Anemia……☐ Yes ☐ No
Asthma……☐ Yes ☐ No
Behavioral/Learning disorder. ☐ Yes ☐ No
Bleeding disorder……..☐ Yes ☐ No
Brain Injury……..☐ Yes ☐ No
Cancer……..☐ Yes ☐ No
Cerebral palsy……..☐ Yes ☐ No
Chicken pox……☐ Yes ☐ No
Congenital heart disease…… ☐ Yes ☐ No
Diabetes…… ☐ Yes ☐ No
Epilepsy……..☐ Yes ☐ No
Handicaps/Disabilities……☐ Yes ☐ No
Hay fever……☐ Yes ☐ No
Hearing problem……..☐ Yes ☐ No
Heart condition……☐ Yes ☐ No
Hepatitis A B C (circle)…..☐ Yes ☐ No
Kidney/Liver problem……..☐ Yes ☐ No
Latex sensitivity……..…..☐ Yes ☐ No
Lung problem……. ☐ Yes ☐ No
Measles/Mumps……..☐ Yes ☐ No
Mononucleosis……☐ Yes ☐ No
Nervous disorders……... ☐ Yes ☐ No
Psychiatric/Psychological…☐ Yes ☐ No
Rheumatic/Scarlet fever……☐ Yes ☐ No
Sickle cell anemia……☐ Yes ☐ No
Stomach problem……..…☐ Yes ☐ No
Tuberculosis…….……☐ Yes ☐ No

Other?..... ☐ Yes ☐ No Please specify _____
_____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian_____Date_____