



## MEDICAL HISTORY

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Is child under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

Is the child receiving any medications or drugs?  Yes  No

If yes, please list and explain reason for taking: \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No

If yes, please explain: \_\_\_\_\_

Has your child ever had surgery?  Yes  No

If yes, please explain: \_\_\_\_\_

Is your child allergic to  Penicillin  Codeine  Latex, Metals, Plastics  Local Anesthetics (Novocaine)

Other – which ones? \_\_\_\_\_

Are there any emotional problems? Explain: \_\_\_\_\_

### Please check the following to indicate "YES" regarding this patient:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Aphthous ulcers frequent (canker sores)         | <input type="checkbox"/> Speech impaired/unusual speech habits   | <input type="checkbox"/> Nursing or bottle habit |
| <input type="checkbox"/> Breath odor                                     | _____  | <input type="checkbox"/> Teeth grinding          |
| <input type="checkbox"/> Herpetic lesions frequent (cold sores)          | <input type="checkbox"/> Strong gag reflex   | <input type="checkbox"/> Teeth clenching         |
| <input type="checkbox"/> Earaches  | <input type="checkbox"/> Frequent vomiting   | <input type="checkbox"/> Mouth bleeding          |
| <input type="checkbox"/> Headaches                                       | <input type="checkbox"/> Smoking   | <input type="checkbox"/> Nail biting             |
| <input type="checkbox"/> Jaws making clicking, grinding or popping noise | <input type="checkbox"/> Chewing tobacco   | <input type="checkbox"/> Lip or sucking          |
| <input type="checkbox"/> Neck pain                                       | <input type="checkbox"/> Self-induced purging (bulimia)  |  |
| <input type="checkbox"/> Orthodontic concerns (crooked teeth or bite)    | <input type="checkbox"/> Finger-sucking: <input type="checkbox"/> frequent <input type="checkbox"/> occasionally |  |
| <input type="checkbox"/> Snore at night                                  | <input type="checkbox"/> Thumb-sucking: <input type="checkbox"/> frequent <input type="checkbox"/> occasionally  |  |
| <input type="checkbox"/> Frequent consumption of carbonated beverages    | <input type="checkbox"/> Pacifier: <input type="checkbox"/> frequent <input type="checkbox"/> occasionally       |  |

### Check if child has any history or difficulty with any of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> ADD (Attention Deficit Disorder)  | <input type="checkbox"/> Heart murmur  |
| <input type="checkbox"/> ADHD (Attention Deficit Hyperactive Disorder)                               | <input type="checkbox"/> Heart condition – explain _____   |
| <input type="checkbox"/> AIDS (HIV)  | _____  |
| <input type="checkbox"/> Anemia  | (NOTE: Your child may require antibiotic prior to dental treatment.)                                       |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Hepatitis type: A B C Other   |
| <input type="checkbox"/> Anorexia  | <input type="checkbox"/> Hives or skin rash  |
| <input type="checkbox"/> Asthma _____ frequency of attacks <input type="checkbox"/> exercise-induced | <input type="checkbox"/> Liver disease   |
| <input type="checkbox"/> Autism  | <input type="checkbox"/> Malignancies  |
| <input type="checkbox"/> Bladder   | <input type="checkbox"/> Mastoid   |
| <input type="checkbox"/> Bleeding problems   | <input type="checkbox"/> Measles   |
| <input type="checkbox"/> Blood pressure concerns   | <input type="checkbox"/> Mononucleosis   |
| <input type="checkbox"/> Blood transfusion – explain _____   | <input type="checkbox"/> Mumps   |
| <input type="checkbox"/> Bruises easily  | <input type="checkbox"/> Nervousness   |
| <input type="checkbox"/> Chicken pox   | <input type="checkbox"/> Persistent cough or coughing up blood   |
| <input type="checkbox"/> Convulsions/Epilepsy/Seizures   | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Thyroid   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Fainting spells   | <input type="checkbox"/> Venereal disease  |
| <input type="checkbox"/> Hearing impaired  | <input type="checkbox"/> Surgery or radiation treatment for tumor, growth or condition of the head or neck |