Medical and Dental History Form

Please complete the following form so we may better serve your child

Child's name: _____ Date of Birth:_____ Gender: ☐ Female ☐ Male

What is the main reason you brought your child to us today? _____

Has your child ever had any of the following?	Yes	No	Comments
Heart Murmur			
Congenital heart disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular, or other Endocrine Disease			
Liver Disease/Hepatitis/Jaundice			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures/Convulsions/Loss of Consciousness			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Cancer			
Speech disorder			
Hearing disorder			
Sight or eye disorder			
Frequent Headaches			
Mental, Emotional, or Developmental delays			
Autism, ADHD, Genetic Disorder/ Syndrome (please note)			
Frequent infections			
Has your child ever received blood/blood products?			
Has your child ever been hospitalized?			
Has your child ever been seriously ill?			
Has your child ever had any significant injury?			
Has your child ever had surgery?			
Which medicines does your child take at this time?			
Is your child allergic …….			
……. to any medicines?			please list
…….to any foods, environmental pollutants, animal?			please list

Does your child have any special needs?_____

Is there any other problem, disease, or medical condition that we should know about in order to care for your child?

☐No ☐Yes Please list _____

Who is your child's Primary Physician or Physician's Group?

Name _____ in _____ Phone _____

Has your child had any of the following:	Yes	No	Comments
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck or other oral habit			
Does your child have any other dental condition			

Which of the following categories best describes your child's learning abilities? ☐ Delayed ☐ Normal ☐ Advanced

How do you think your child will cooperate for this appointment? ☐ Well-behaved ☐ Unsure ☐ Uncooperative

_____ _____ _____

Parent/Guardian Signature Date Reviewed by DDS, DMD