

Child Medical History

Patient's Name: _____

Date: _____

Please describe your child's current physical health:

Good Fair Poor
Currently under the care of a physician? Yes No
If no, Please explain: _____

Name of Physician: _____
Physician Phone #: _____

Please list all prescription/over the counter drugs that your child is currently taking:

1. Medication: _____ Taken for: _____
2. Medication: _____ Taken for: _____
3. Medication: _____ Taken for: _____

Has puberty begun? Yes No Has menstruation begun (girls)? Yes No
Females: Is your child pregnant? Yes No Weeks #'s _____

Does your child have any of the following medical conditions which require pre-medication? (Please circle)

Y N Artificial Heart Valve **Y N** Congenital Heart Disease/Defect (CHD)
Y N Heart Transplant **Y N** History of Infective Endocarditis
Does your child need pre-medication for dental procedures? Yes No
If yes, please explain: _____

Has your child ever had any of the following medical conditions? (Please circle)

Y N Abnormal Bleeding/Anemia	Y N Hepatitis
Y N ADD/ADHD	Y N HIV+/AIDS
Y N Artificial Bones/Joints/Valves	Y N Hospitalized for Any Reason
Y N Asthma/Difficulty Breathing	Y N Kidney/Liver Problems
Y N Birth Defects/Hereditary Problems	Y N Mental Health problems
Y N Cancer/Chemotherapy	Y N Rheumatic/Scarlet Fever
Y N Diabetes	Y N Tonsil/Adenoid Condition
Y N Epilepsy/Seizure/Convulsions	Y N Tuberculosis (TB)
Y N Frequent Headaches/Migraines	Y N Vision, Hearing, Speech Difficulties
Y N Handicaps/Disabilities	Y N Other (Describe below)
Y N Hemophilia	

Please discuss any medical problems your child has had: _____

Does your child have any of the following habits? (Please circle)

Y N Clenching/Grinding Teeth	Y N Nursing Bottle Habit
Y N Lip Sucking/Biting	Y N Speech Problems
Y N Mouth Breather	Y N Thumb/Finger Sucking
Y N Nail Biting	Y N Tongue Thrust

Please include any additional information concerning habits: _____

Is your child allergic to any of the following? (Please circle)

Y N Acetaminophen (Tylenol)	Y N Dental Anesthetics	Y N Metals (Nickel)
Y N Acrylic/Plastics	Y N Ibuprofen	
Y N Aspirin	Y N Latex	

Please list any other drugs/materials that you are allergic to: _____

I understand that the information that I have given today concerning my child is correct to the best of my knowledge. I also understand that this information will be held in the confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature of parent or guardian: _____

Date: _____