Patient Medical History and Information

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F

Name of Medical Doctor:_____ Phone _____

List all the medications or drugs patient is now taking:
[ ] None_____
_____

List all the medications or drugs patient is allergic to:
[ ] None_____
_____

Has your child ever had any of the following medical problems?

[ ] Y [ ] N HANDICAPS/DISABILITIES
[ ] Y [ ] N HEARING IMPAIRMENT
[ ] Y [ ] N HEART MURMUR
[ ] Y [ ] N HEMOPHILIA
[ ] Y [ ] N HEPATITIS
[ ] Y [ ] N HIV+/ AIDS
[ ] Y [ ] N KIDNEY/LIVER PROBLEMS
[ ] Y [ ] N RHEUMATIC/SCARLET FEVER
[ ] Y [ ] N SICKLE CELL DISEASE/TRAITS
[ ] Y [ ] N TUBERCULOSIS (TB)
[ ] Y [ ] N ABNORMAL BLEEDING
[ ] Y [ ] N ADD/ADHD
[ ] Y [ ] N HOSPITAL STAYS
[ ] Y [ ] N OPERATIONS
[ ] Y [ ] N ARTIFICIAL BONES/JOINTS/VALVES
[ ] Y [ ] N ASTHMA
[ ] Y [ ] N CANCER
[ ] Y [ ] N CONGENITAL HEART DEFECT
[ ] Y [ ] N CONVULSIONS/EPILEPSY
[ ] Y [ ] N DRUG ALLERGIES
[ ] Y [ ] N DIABETES

Answer the following questions regarding the child's overall health.

[ ] Y [ ] N IS THE CHILD'S WATER FLUORIDATED
[ ] Y [ ] N DOES THE CHILD TAKE FLUORIDATED SUPPLEMENTS
[ ] Y [ ] N HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN JAW (TMJ/TMD)
[ ] Y [ ] N DOES THE CHILD BRUSH DAILY
[ ] Y [ ] N DOES THE CHILD FLOSS DAILY
[ ] Y [ ] N IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN
[ ] Y [ ] N HAS YOUR CHILD EVER TAKEN FOSAMAX OR BISPHOSPHONATE
[ ] Y [ ] N HAS YOUR CHILD EVER TAKEN PHEN-PHEN

Does your child have any of the following habits?

[ ] Y [ ] N LIP SUCKING
[ ] Y [ ] N NAIL BITING
[ ] Y [ ] N NURSING BOTTLE HABITS
[ ] Y [ ] N THUMB/FINGER SUCKING
[ ] Y [ ] N TOBACCO USE

[ ] Y [ ] N Is your child allergic to any materials?

Please list:
_____
_____

Please discuss any serious medical problems that your child has had: [NONE]

_____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Is your child in pain? _____

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

Signature_____Date_____

Medical History Update

1. Signature_____Date_____
Comments_____
_____

2. Signature_____Date_____
Comments_____
_____