

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you; your records are confidential. If you need help please ask us – we will be happy to assist you.

*****Please Note That You Are Answering These Questions for Your CHILD And Not Yourself*****

MEDICAL

The name, address and phone number of my pediatrician is _____

Are you under a physician's care now? Yes No _____

Did you have a full term pregnancy with your child? Yes No _____

Have you ever been in the NICU, hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Are you taking any medications, pills, or drugs? Yes No _____

Does your child have ADD, ADHD, PDD, Autism, or on the spectrum? Yes No _____

Are you on a special diet (Gluten free, no red dye, etc)? Yes No _____

TEENAGE Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Amoxicillin Gluten Metal Latex Local Anesthetics
 Any other medicines or Foods. If yes please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to me or my child's health. If I ever have any change in my health or change in my medication, I will inform the dentist, hygienist, or the dental office.

Signature of Patient (or legal guardian) _____ / _____ Date

Relationship to patient (Mom, Dad, etc) _____

Signature of DENTIST _____ / _____ Date

Signature of HYGIENEST _____ / _____ Date