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Pediatric Patient Medical History Information

Dear Parent:

This medical history form, although lengthy, is designed to help eliminate potential dangers your child could encounter in a dental office. These dangers can result from the doctor not being aware of your child's medical condition. Although some questions may appear unrelated to your child's dental treatment, we assure you they are in fact essential to your child's safety. Please take the time to answer each question to the best of your ability.

GENERAL INFORMATION

Name of your child or young adult: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: O M O F

Physician's or Pediatrician's Name: _____ Phone number: _____

Address: _____ City: _____ State: _____

Who may we contact in case of emergency other than parent: _____

Home phone: _____ Work phone: _____

Relationship to your child: _____

HISTORY OF MEDICAL CONDITION AND ILLNESSES

KEY **N-**Never had this condition **P-** Previously had this condition **C-**Currently have this condition

Please mark the appropriate response for each of the following:

BONE AND JOINT DISORDERS

Rheumatoid Arthritis	O **N**	O **P**	O **C**
Osteoarthritis	O **N**	O **P**	O **C**
Joint Prosthesis	O **N**	O **P**	O **C**

Other:

HEART DISORDERS

Heart Murmur	O **N**	O **P**	O **C**
Heart valve disorder	O **N**	O **P**	O **C**

Other:

MUSCLE DISORDERS

Muscle tension	O **N**	O **P**	O **C**
Muscular Dystrophy	O **N**	O **P**	O **C**
Frequent muscle spasms	O **N**	O **P**	O **C**

Other:

BLOOD DISORDERS

Prolonged Bleeding	O **N**	O **P**	O **C**
Anemia	O **N**	O **P**	O **C**
Leukemia	O **N**	O **P**	O **C**
Sickle Cell	O **N**	O **P**	O **C**
Cancer	O **N**	O **P**	O **C**

Other:

HIV DISORDERS

AIDS	O **N**	O **P**	O **C**
ARC	O **N**	O **P**	O **C**
HIV Positive	O **N**	O **P**	O **C**

NERVE DISORDERS

Cerebral Palsy	O **N**	O **P**	O **C**
Epilepsy	O **N**	O **P**	O **C**
Neuralgia	O **N**	O **P**	O **C**
Multiple Sclerosis	O **N**	O **P**	O **C**
Brain Injury	O **N**	O **P**	O **C**

Other:

ENDOCRINE (GLAND) DISORDERS

Diabetes	O **N**	O **P**	O **C**

Other:

KIDNEY, URINARY DISORDERS

Kidney Disease	O **N**	O **P**	O **C**
Bladder Infections	O **N**	O **P**	O **C**

Other:

STOMACH, INTESTINAL DISORDERS

Hiatal Hernia	O **N**	O **P**	O **C**

Other:

EYE DISORDERS

Glaucoma	O **N**	O **P**	O **C**
Ocular Herpes	O **N**	O **P**	O **C**

Does your child wear contacts? O **Yes** O **No**

Other:

LIVER DISEASE

Hepatitis A (Infectious)	O **N**	O **P**	O **C**
Hepatitis B Serum	O **N**	O **P**	O **C**

Other:

OTHER CONDITIONS

Psychiatric disorders	O **N**	O **P**	O **C**
Tumors or malignancies	O **N**	O **P**	O **C**
Venereal Disease	O **N**	O **P**	O **C**
Radiation treatment	O **N**	O **P**	O **C**
Whiplash injury	O **N**	O **P**	O **C**
Pain in jaw joints	O **N**	O **P**	O **C**
TMJ problems	O **N**	O **P**	O **C**

Other:

HEADACHE

Tension Headache	O **N**	O **P**	O **C**
Migraine Headache	O **N**	O **P**	O **C**
Unexplained Headache	O **N**	O **P**	O **C**

Other:

LUNG DISORDERS

Asthma	O **N**	O **P**	O **C**
Emphysema	O **N**	O **P**	O **C**
Tuberculosis	O **N**	O **P**	O **C**
Difficulty breathing	O **N**	O **P**	O **C**

Other:

PLEASE MARK YES OR NO TO THE FOLLOWING IMPORTANT QUESTIONS:

1. Is your child allergic to (itching, rash, hives, swelling of hands, feet or eyes) or had an adverse reaction to (made sick from):

Penicillin	o YES	o NO	Food	o YES	o NO
Aspirin	o YES	o NO	Animals	o YES	o NO
Codeine	o YES	o NO	Pollen	o YES	o NO
Local anesthetic	o YES	o NO	Dust …….……..	o YES	o NO
Medications or drugs	o YES	o NO	Insects or bee stings	o YES	o NO

2. Has your child ever had a Rheumatic Fever? ..... o YES o NO
3. Has your child developed Rheumatic Heart Disease as a result? ..... o YES o NO
4. Has your child ever bled excessively after being cut or injured? ..... o YES o NO
5. Has your child been a patient in the hospital in the last three (3) years? ..... o YES o NO
6. Has your child been under care of a physician during the past (2) years? ..... o YES o NO
   Is your child receiving physician's care now? _____
   If so, what is the nature of the care? _____
   _____
   _____
   _____
7. Does your child have any diseases, condition or problem not listed or that should be brought to the dentist's attention? ..... o YES o NO
8. Has your child ever fainted? ..... o YES o NO
9. Has your child ever had any radiation or chemotherapy? ..... o YES o NO
10. Would you like to speak privately to the Doctor about any problem? ..... o YES o NO

MEDICATIONS

List all medications your child is taking now, the dosage, how often and the reasons.

Medication	Dosage	How often?	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has any changes in his/her health, or if their medications change, I will inform the doctor of dentistry at the next appointment without fail.

_____	_____	_____
Date	Parent's Signature	Doctor's Signature

Supplemental Health History Form

Patients Name: _____ File #: _____

Has your child ever been diagnosed with, or shown any signs of the following behavioral conditions:

- O Autism – Level _____
- O ADHD
- O Tourette Syndrome
- O Anxiety Disorder
- O Depression
- O Cerebral Palsy

If yes, date of diagnosis: _____

Parent/Guardian signature: _____ Date: _____

SUBMIT FORM