PEDIATRIC PATIENT MEDICAL HISTORY INFORMATION

VALLEY OAK
DENTAL GROUP
1507 West Yosemite Avenue
Manteca, California 95337
(209) 823-9341

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.

Thank-you.

VALLEY OAK DENTAL GROUP

General Information

Name of child or young adult: ______________________ Date: __________

Age: ________ Date of Birth: ______________ Sex (Check One): ☐ Male ☐ Female

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 circle the appropriate response for each of the following:

BONE AND JOINT DISORDERS

Rheumatoid Arthritis	N	P	C
Osteoarthritis	N	P	C
Joint Prosthesis	N	P	C
Other ____________	N	P	C

BLOOD DISORDERS

Prolonged Bleeding	N	P	C
Anemia	N	P	C
Leukemia	N	P	C
Sickle Cell	N	P	C
Cancer	N	P	C
Other ____________	N	P	C

ENDOCRINE (GLAND) DISORDERS

Diabetes	N	P	C
Other ____________	N	P	C

EYE DISORDERS

Glaucoma	N	P	C
Occular Herpes	N	P	C
Does your child wear contacts?	N	P	C
Other ____________	N	P	C

HEADACHE

Tension Headache	N	P	C
Migraine Headache	N	P	C
Unexplained Headache	N	P	C
Other ____________	N	P	C

HEART DISORDERS

Heart Murmur	N	P	C
Heart Valve Disorder	N	P	C
Other ____________	N	P	C

HIV DISORDERS

AIDS	N	P	C
ARC	N	P	C
HIV Positive	N	P	C

KIDNEY, URINARY DISORDERS

Kidney Disease	N	P	C
Bladder Infections	N	P	C
Other ____________	N	P	C

LIVER DISEASE

Hepatitis A (Infectious)	N	P	C
Hepatitis B Serum	N	P	C
Other ____________	N	P	C

LUNG DISORDERS

Asthma	N	P	C
Emphysema	N	P	C
Tuberculosis	N	P	C
Difficulty breathing	N	P	C
Other ____________	N	P	C

MUSCLE DISORDERS

Muscle tension	N	P	C
Muscular Dystrophy	N	P	C
Frequent muscle spasms	N	P	C
Other ____________	N	P	C

NERVE DISORDERS

Cerebral Palsy	N	P	C
Epilepsy	N	P	C
Neuralgia	N	P	C
Multiple Sclerosis	N	P	C
Brain Injury	N	P	C
Other ____________	N	P	C

STOMACH, INTESTINAL DISORDERS

Hiatal Hernia	N	P	C
Other ____________	N	P	C

OTHER CONDITIONS

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

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Please circle 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	YES	NO	Food	YES	NO
Aspirin	YES	NO	Animals	YES	NO
Codeine	YES	NO	Pollen	YES	NO
Local anesthetic	YES	NO	Dust	YES	NO
Medications or drugs	YES	NO	Insect or bee stings	YES	NO

2. Has your child ever had Rheumatic Fever? .... YES NO
3. Has your child developed Rheumatic Heart Disease as a result? .... YES NO
4. Has your child ever bled excessively after being cut or injured? .... YES NO
5. Has your child been a patient in the hospital in the last three (3) years? .... YES NO
6. Has your child been under the care of a physician during the past two (2) years? .... YES NO

   Is your child receiving physician's care now? ________ If so, what is the nature of the care? ________

7. Does your child have any disease, condition or problem not listed or that should be brought to the dentist's attention? .... YES NO
8. Has your child ever fainted? .... YES NO
9. Has your child ever had any radiation or chemotherapy? .... YES NO
10. Would you like to speak privately to the Doctor about any problem? .... YES NO

Medication

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 change 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