

YOUR CHILD'S MEDICAL HISTORY

Name:	Nickname:	Date:
DOB:		Medical Alert:

Your Child's Physician: Name: _____ Tele: _____

Address: _____

Is your child under the care of a physician? *Yes/No*. Please describe: _____

Is your child taking any medications? *Yes/No*. Please describe: _____

Have you ever been told your child needs antibiotics or premeds before dental treatments?
Yes/No. If yes, please name medication: _____

Does your child have any allergic to any medication/ substances? *Yes/No*.
 If yes, please name: _____

Are your child's immunizations current? *Yes/No*

List any hospitalizations, surgeries, serious illnesses: _____

Indicate which of the conditions your child has now or ever has had. Circle each answer individually.

Abnormal bleeding	Y/ N	Diabetes	Y/N	Latex sensitive	Y/ N
AIDS/HIV +	Y/N	Epilepsy	Y/N	Measles	Y/N
Allergies/Hives	Y/N	Disability	Y/N	Mononucleosis	Y/N
Anemia	Y/N	Hay fever	Y/N	Mumps	Y/N
Asthma	Y/N	Hearing problems	Y/N	Neurological disorder	Y/N
Cancer	Y/N	Heart murmur	Y/N	Psychiatric	Y/N
Chicken pox	Y/N	Hemophilia	Y/N	Rheumatic fever	Y/N
Congenital heart dz	Y/N	Hepatitis	Y/N	Stomach problems	Y/N
Convulsions	Y/ N	Kidney problems	Y/N	Tuberculosis	Y/N

Others (not listed above) _____

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/ Guardian _____ Date: _____