



Your Child's Medical History

Your Child's Name: _____

Birth Date: _____ Medical Alerts: _____

Is your child under the care of a physician? _____

Your Child's Physician: _____ Phone #: _____

Is your child taking any medications? _____ If so, please describe: _____

Does your child have any allergies (medications, etc.)? _____

Have you ever been told that your child needs to take antibiotics before his/her dental appointments? _____ Is so, for what condition? _____

Are your child's immunizations up-to-date? _____

Indicate which of the conditions your child has now or has had (Please check if it applies):

AIDS/HIV positive _____ Congenital Heart Disease _____ Lung Problem _____
Allergies/Hives _____ Diabetes _____ Measles/Mumps _____ Anemia _____
Epilepsy _____ Mononucleosis _____ Asthma _____ Handicaps/Disabilities _____
Nervous Disorders _____ Behavioral/Learning Problems _____ Hay Fever _____
Psychiatric Problems _____ Bleeding Disorder _____ Hearing Problem _____
Rheumatic/Scarlet Fever _____ Brain Injury _____ Heart Condition _____
Sickle Cell Anemia _____ Cancer _____ Hepatitis A, B, C _____ Stomach Problems _____
Cerebral Palsy _____ Kidney/Liver Problem _____ Tuberculosis _____ Chicken Pox _____
Latex Sensitivity _____

Any other conditions that may not be listed above: _____

List any Hospitalizations, Surgeries, and Serious Illnesses:

_____ When: _____
_____ When: _____

I understand that the above information will be used for my child's dental health. I have answered the questions to the best of my ability. If further information is needed you may contact my child's health care physician for any other information.

Signature of
Parent/Guardian: _____ Date: _____