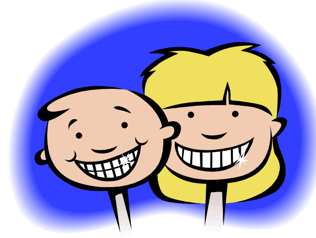

# Your Child's Medical History

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__________ Congential 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:_______________