



## MEDICAL HISTORY

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone (    ) \_\_\_\_\_  
 \_\_\_\_\_  
 Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Is child under the care of a physician?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Is the child receiving any medications or drugs?  Yes  No  
 If yes, please list and explain reason for taking: \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Has your child ever had surgery?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Is your child allergic to  Penicillin     Codeine     Latex, Metals, Plastics     Local Anesthetics (Novocaine)  
 Other – which ones? \_\_\_\_\_

Are there any emotional problems? Explain: \_\_\_\_\_

**Please check the following to indicate "YES" regarding this patient:**

<input type="checkbox"/> Aphthous ulcers frequent (canker sores)	<input type="checkbox"/> Speech impaired/unusual speech habits	<input type="checkbox"/> Nursing or bottle habit
<input type="checkbox"/> Breath odor	_____	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Herpetic lesions frequent (cold sores)	<input type="checkbox"/> Strong gag reflex	<input type="checkbox"/> Teeth clenching
<input type="checkbox"/> Earaches	<input type="checkbox"/> Frequent vomiting	<input type="checkbox"/> Mouth bleeding
<input type="checkbox"/> Headaches	<input type="checkbox"/> Smoking	<input type="checkbox"/> Nail biting
<input type="checkbox"/> Jaws making clicking, grinding or popping noise	<input type="checkbox"/> Chewing tobacco	<input type="checkbox"/> Lip or sucking
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Self-induced purging (bulimia)	
<input type="checkbox"/> Orthodontic concerns (crooked teeth or bite)	<input type="checkbox"/> Finger-sucking: <input type="checkbox"/> frequent <input type="checkbox"/> occasionally	
<input type="checkbox"/> Snore at night	<input type="checkbox"/> Thumb-sucking: <input type="checkbox"/> frequent <input type="checkbox"/> occasionally	
<input type="checkbox"/> Frequent consumption of carbonated beverages	<input type="checkbox"/> Pacifier: <input type="checkbox"/> frequent <input type="checkbox"/> occasionally	

**Check if child has any history or difficulty with any of the following:**

<input type="checkbox"/> ADD (Attention Deficit Disorder)	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> ADHD (Attention Deficit Hyperactive Disorder)	<input type="checkbox"/> Heart condition – explain _____
<input type="checkbox"/> AIDS (HIV)	_____
<input type="checkbox"/> Anemia	(NOTE: Your child may require antibiotic prior to dental treatment.)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis    type:    A    B    C    Other
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Hives or skin rash
<input type="checkbox"/> Asthma _____ frequency of attacks <input type="checkbox"/> exercise-induced	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Autism	<input type="checkbox"/> Malignancies
<input type="checkbox"/> Bladder	<input type="checkbox"/> Mastoid
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Measles
<input type="checkbox"/> Blood pressure concerns	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Blood transfusion – explain _____	<input type="checkbox"/> Mumps
<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Persistent cough or coughing up blood
<input type="checkbox"/> Convulsions/Epilepsy/Seizures	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Depression	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Surgery or radiation treatment for tumor, growth or condition of the head or neck