

CHILD MEDICAL HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | | | | | |
|---|---|------------------------------------|---|---|------------------------------|
| Y | N | ABNORMAL BLEEDING | Y | N | DIABETES |
| Y | N | ADD / ADHD | Y | N | HANDICAPS / DISABILITIES |
| Y | N | ALLERGIES TO ANY DRUGS | Y | N | HEARING IMPAIRMENT |
| Y | N | ALLERGIC TO LATEX / METALS | Y | N | HEART MURMUR |
| Y | N | ALLERGIC TO PLASTIC | Y | N | HEMOPHILIA |
| Y | N | ANY HOSPITAL STAYS | Y | N | HEPATITIS |
| Y | N | ANY OPERATIONS | Y | N | HIV+ / AIDS |
| Y | N | ARTIFICIAL BONES / JOINTS / VALVES | Y | N | KIDNEY PROBLEMS |
| Y | N | ASTHMA | Y | N | LIVER PROBLEMS |
| Y | N | CANCER | Y | N | LUPUS |
| Y | N | CONGENITAL HEART DEFECT | Y | N | RHEUMATIC / SCARLET FEVER |
| Y | N | CONVULSIONS / EPILEPSY | Y | N | SICKLE CELL DISEASE / TRAITS |
| | | | Y | N | TUBERCULOSIS (TB) |

ANY OTHER MEDICAL CONCERNS WE SHOULD BE AWARE OF?

CHILD'S PHYSICIAN: _____ PHONE # _____ LAST VISIT _____

DOES YOUR CHILD NEED TO BE PREMEDICATED BEFORE DENTAL APPOINTMENTS? _____ YES _____ NO
HAVE TONSILS AND ADENOIDS BEEN REMOVED? TONSILS _____ YES ADENOIDS _____ YES
LIST ANY MEDICATIONS OR HERBAL SUPPLEMENTS NOW BEING TAKEN. GIVE REASONS FOR MEDICATION

LIST ANY ALLERIGIES OR DRUG SENSITIVITY: _____
HAS PATIENT REACHED PUBERTY? GIRLS – HAS SHE STARTED MENSTRUATING _____ YES _____ NO
BOYS - HAS HIS VOICE CHANGED _____ YES _____ NO

DENTAL HISTORY

LIST REASON FOR TODAY'S CONSULTATION:

LIST ANY MUSICAL INSTRUMENTS PLAYED: _____

HAS PATIENT HAD PRIOR ORTHODONTIC TREATMENT? _____ YES _____ NO
HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ YES _____ NO
HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE: _____ YES _____ NO
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ YES _____ NO
IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE _____ YES _____ NO WHILE ASLEEP _____ YES _____ NO
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES _____ NO
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ YES _____ NO

MAY WE TAKE AN XRAY TODAY (AT NO EXPENSE TO YOU) TO HELP US GIVE YOU THE MOST ACCURATE INFORMATION POSSIBLE AT THIS CONSULTATION APPOINTMENT? _____ YES _____ NO

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO CONTACT THIS OFFICE WITH ANY CHANGES IN MY CHILD'S MEDICAL/DENTAL STATUS.

SIGNATURE OF PARENT OR GUARDIAN

TODAY'S DATE

I UNDERSTAND THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF PATIENTS WHERE APPROPRIATE IN DETERMINING A PAYMENT PLAN.

SIGNATURE OF PARENT OR GUARDIAN

TODAY'S DATE