# CHILD'S MEDICAL HISTORY

NAME:______________________________________ BIRTHDATE:__________________________

PHYSICIAN'S NAME:________________________________________________

1. IS YOUR CHILD IN ANY PAIN AT THIS TIME? YES NO
2. HAS YOUR CHILD BEEN UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM AT THIS TIME? YES NO

   IF SO, WHAT FOR?______________________________________________________________

3. IS YOUR CHILD ALLERGIC TO ANY FOODS, MEDICATIONS OR DRUGS? YES NO

   PLEASE LIST:________________________________________________________________________________

4. DOES YOUR CHILD TAKE ANY MEDICATIONS AT THIS TIME? YES NO

   PLEASE LIST:________________________________________________________________________________________

5. HAS YOUR CHILD HAD AN UNFAVORABLE REACTION TO ANY MEDICATION? YES NO
6. HAS YOUR CHILD EVER HAD ANY EMOTIONAL, MENTAL, OR NERVOUS PROBLEMS? YES NO
7. PLEASE CIRCLE IF YOURE CHILD HAS HAD ANY OF THE FOLLOWING:

CLEFT PALATE/LIP SPEECH PROBLEMS HEART DISEASE HEART MURMER ANEMIA

RHEUMATIC FEVER SCARLET FEVER CHRONIC COUGH ASTHMA HAY FEVER

ALLERGIES/HIVES DIABETES CHEMOTHERAPY AIDS/HIV MOUTH SORES

HEPATITIS A,B,C LIVER DISEASE JAUNDICE SICKLE CELL HEMOPHILIA

COLD SORES FEVER BLISTERS SEIZURES PSYCHIATRIC TREATMENT

EPILEPSY KIDNEY DISEASE BLOOD TRANSFUSION

8. HAS YOUR CHILD EVER HAD ANY EXCESSIVE BLEEDING REQUIRING TREATMENT? YES NO
9. HAS YOUR CHILD EVER HAD AN UNUSUAL REACTION TO DENTAL ANESTHETIC (NOVACAINE, XYLOCAINE)? Yes NO
10. HAS YOUR CHILD EVER HAD ANYH OPERATIONS OR SURGERIES? YES NO

    LIST:________________________________________________________________________________

11. DOES YOUR CHILD SUCK ON THEIR FINGERS, THUMB, ETC? YES NO
12. HAS YOUR CHILD INHERITED ANY SPECIAL DENTAL CHARACTERISTICS? YES NO
13. DOES YOUR CHILD HAVE ANY SPECIFIC DENTAL PROBLEMS NOT MENTIONED ABOVE?

    LIST:_________________________________________________________________________

14. IS THEIR FIRST DENTAL VISIT? YES NO

PARENT/GUARDIAN SIGNATURE:_____________________________________________ DATE:_________________

DOCTOR____________________________________________