

Pediatric Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes []
Have you ever been hospitalized or had a major operation? Yes No If yes []
Have you ever had a serious head or neck injury? Yes No If yes []
Are you taking any medications, pills, or drugs? Yes No If yes []
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes []
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes []
Are you on a special diet? Yes No
Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No If yes []
Other? If yes []

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No
Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No
Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anemia Yes No
Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes No High Blood Pressure Yes No
Rheumatism Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes No
Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No
Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No
Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No
Breathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No
Bruise Easily Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No Cancer Yes No
Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No Chemotherapy Yes No
Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes No Chest Pains Yes No
Heart Attack/Failure Yes No Tuberculosis Yes No Cold Sores/Fever Blisters Yes No Heart Murmur Yes No
Pain in Jaw Joints Yes No Tumors or Growths Yes No Congenital Heart Disorder Yes No Heart Pacemaker Yes No
Parathyroid Disease Yes No Ulcers Yes No Convulsions Yes No Heart Trouble/Disease Yes No
Psychiatric Care Yes No Venereal Disease Yes No Yellow Jaundice Yes No ADHA Yes No
Autism Yes No Diabetes (Type 1 or 2) Yes No Depression Yes No Anxiety Yes No
Cerebral Palsy Yes No GERD Yes No

Have you ever had any serious illness not listed Yes No If yes []

Comments:

[]

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____