PATIENT'S NAME ____________________

DOB ____________________

CHILD'S MEDICAL HISTORY - DENTAL HISTORY

MEDICAL HISTORY

DATE: ____________________

Child's Physician ____________________ Date Last Seen ____________________

Address of your child's Physician ____________________ Office Phone ____________________

1. Is your child in good health? .... ☐ Yes ☐ No ☐ Don't Know

1. Does your child have a health problem? .... ☐ Yes ☐ No ☐ Don't Know

If yes, explain ____________________

Has your child ever had or been treated by a physician for:

Condition	Yes	No	?
Problems at Birth			
Heart Murmur			
Heart Disease			
Rheumatic Fever			
Anemia			
Sickle Cell Anemia			
Bleeding/Hemophilia			
Blood Transfusion			
Hepatitis			
AIDS or HIV+			
Tuberculosis			
Liver Disease			
Kidney Disease			
Diabetes			

Condition	Yes	No	?
Arthritis			
Cancer			
Cerebral Palsy			
Seizures			
Autism			
Asthma			
Cleft Lip/Palate			
Speech Problems			
Hearing Problems			
Eye Problems			
Skin Problems			
Tonsil/Adenoid Problems			
Sleep Problems			
Emotional/Behavior Problems			
Gastro Esophageal Reflux Disease			

If yes to any above, please explain: ____________________

____

Other problems: ____________________

Allergies (Please list) ____________________

Past medications taken by child: ____________________

Daily medications taken by child: ____________________

(over)