Pediatric Dentistry & Family Orthodontics

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UPDATED PATIENT MEDICAL HISTORY

Today's Date____________________

Patient Name____ **DOB**__________________________________
Physical Address ____**City**___________________**ZipCode**_______
Mailing Address (If different) ____
Home Phone__________________________________ **Cell Phone**_____________________________________
Work Phone ________________________ **Email**____

Please list all of your child's Medical Professionals:

Name of Physician/Pediatrician ______________________________ Phone__________________________________
Address ____ City _____________________ Zip Code__________
Date of Last Exam_________________

Name of Specialist(s) ____ Specialty ____________________________
Address ____ City _____________________ Zip Code__________
What does this doctor treat your child for? _______________________________ Date of Last Exam ________________

Name of Specialist(s) ____ Specialty ____________________________
Address ____ City _____________________ Zip Code__________
What does this doctor treat your child for? _______________________________ Date of Last Exam ________________

Name of Specialist(s) ____ Specialty ____________________________
Address ____ City _____________________ Zip Code__________
What does this doctor treat your child for? _______________________________ Date of Last Exam ________________

PLEASE CHECK IF YOUR CHILD HAS A HISTORY OF ANY OF THE FOLLOWING, IF YES PLEASE EXPLAIN:

	Yes	No	
Hospitalization or Surgery?	☐	☐	______________________________
Taking any medications or drugs?	☐	☐	______________________________
History of a heart murmur?	☐	☐	______________________________
History of prolonged bleeding?	☐	☐	______________________________

PLEASE CHECK IF YOUR CHILD HAS A HISTORY OF ANY OF THE FOLLOWING, IF YES PLEASE EXPLAIN:

	Yes	No	
Allergic to Penicillin?	☐	☐	______________________________
Allergic to any other medications or food?	☐	☐	______________________________
Any other allergies such as latex?	☐	☐	______________________________
Is currently under the care of a physician for any reason?	☐	☐	______________________________

PLEASE CHECK IF YOUR CHILD HAS/HAD ANY HISTORY OF THE FOLLOWING (Mark all boxes):

	Yes	No		Yes	No		Yes	No		Yes	No
Acid Reflux	□	□	Cerebral Palsy	□	□	Hepatitis	□	□	Premedicate	□	□
ADD	□	□	Chicken Pox	□	□	HIV/AIDS	□	□	Rett's Disorder	□	□
ADHD	□	□	Cleft Palate	□	□	Kidney Problems	□	□	Rheumatic Fever	□	□
Anemia	□	□	Diabetes	□	□	Lactose Intolerant	□	□	Seasonal Allergies	□	□
Asperger's Disorder	□	□	Disabilities	□	□	Liver Disease	□	□	Seizures	□	□
Asthma	□	□	Down Syndrome	□	□	Measles	□	□	Shunts/Prostheses	□	□
Autism Spectrum Disorder	□	□	Epilepsy	□	□	Mentally Disabled	□	□	Special Needs	□	□
Behavior Problems	□	□	Fainting Spells	□	□	Mononucleosis	□	□	Speech Issues	□	□
Bi-Polar Disorder	□	□	Feeding Tube	□	□	Mumps	□	□	STD	□	□
Cancer	□	□	Grind Teeth	□	□	Non-verbal	□	□	Thyroid Disease	□	□
CDD	□	□	Hearing Problems	□	□	PDD-Please Specify	□	□	Tuberculosis	□	□
Celiac Disease	□	□	Heart Defect	□	□	PDD-NOS	□	□	Wheel Chair	□	□

If "YES" to any of the above, please give a brief explanation: ______________________________

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Pre-medication prior to dental appointments? Yes □ No □ If yes, please explain ______________________________

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Please describe/list any **current medical conditions not listed above, any current medical treatments, pending surgeries, recent injuries, special needs,** or any other information that we should be aware of: ______________________________

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MEDICATIONS

Please list all medications with dosage, regimen, the related medical condition, and name of physician which prescribes medication:

Medication, Dosage, Regimen	Medical Condition	Physician prescribing medication
Medication, Dosage, Regimen	Medical Condition	Physician prescribing medication
Medication, Dosage, Regimen	Medical Condition	Physician prescribing medication
Medication, Dosage, Regimen	Medical Condition	Physician prescribing medication
Medication, Dosage, Regimen	Medical Condition	Physician prescribing medication

ACKNOWLEDGEMENT AND AUTHORIZATION

I have answered the above questions to the best of my knowledge. I acknowledge and understand that it is my responsibility to inform the dental office of any changes or updates regarding my child's health or any personal information. I authorize Pediatric Dentistry and Family Orthodontics to perform any necessary dental services that my child may need.

Signature of Legally Responsible Parent/Guardian #1	Date	Print Name
Signature of Legally Responsible Parent/Guardian #2	Date	Print Name