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: _____

_____

_____

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

_____

_____

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: _____

_____

_____

_____

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

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