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(760)730-3456

MEDICAL HISTORY FORM

PATIENT'S NAME:	DATE OF BIRTH:
PATIENT'S PHYSICIAN:	PATIENT'S SCHOOL:
PHYSICIAN'S ADDRESS:	
PHYSICIAN'S PHONE #:	LAST MEDICAL EXAM:
PREVIOUS DENTIST:	LAST DENTAL EXAM:
PATIENT'S ORTHODONTIST:	LAST ORTHODONTIC EXAM:

REASON FOR MAKING THIS APPOINTMENT:_____

MEDICAL HISTORY: (Please select and circle when necessary)	YES	NO	(Please Explain YES Answers)
1. Is your child allergic to anything? Foods, Medications, Latex			
2. Is there a history of any illness/disease such as: Diabetes, Hepatitis, Chicken pox, Herpes, Cancer, Tumors, Asthma, Tuberculosis, STD or Sexually transmitted diseases, HIV, Other?			
3. Any history of the following: Hospitalizations, Surgeries, Premature birth, birth complications, Indwelling catheters, Shunts, Gastric tubes, Seizures			
4. Does your child have any of the following disabilities? Emotional, Neurological, Speech, Learning			
5. Does your child take any medication on a regular schedule?			
6. Have any of the following ever been defective in any way: Eyes, Ears, Heart, Lungs, Kidneys, Liver, Bladder, Intestine, Spleen, Bones			
7. Has your child ever had a bad reaction to any drug, medicine, or anesthetic either in a "shot" or by mouth?			
8. Does your child bleed excessively after cuts or extractions or have any bleeding disorder?			
9. Has your child had any tonsils and/or adenoids been removed or have a history of snoring or sleep apnea?			
10. Has your child had rheumatic fever or infective endocarditis (Heart condition)?			

DENTAL HISTORY: (Please select)	YES	NO	(Please Explain YES Answers)
A. Any unfavorable reaction to dental treatment?			
B. Any habits such as the following and to what age?: Thumb-sucking, Finger-sucking, Pacifier, Other sucking/chewing habits, Grinding, Nail biting			
C. Does child have full charge of his/her own tooth brushing?			
D. Does your child eat "sweets" frequently? How many times a day are sugars or carbohydrates eaten? i.e. Fruit juices, crackers, sports drinks, candy			
E. Is there a history of any severe blow to the teeth, face or head?			
F. Has your child taken fluoride vitamins or drops in the past?			
G. Does your child currently take a fluoride supplement?			
H. Home tap water company (to determine fluoride level)			
I. Home bottled water company (to determine fluoride level)			

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Name of Responsible Party:

Please sign electronic copy at the office

Signature of Responsible Party Date: