Medical History:

Patients Name: ____
Were there any difficulties during pregnancy, delivery (prematurity), or 1st year of life?____.
Was your child breastfed or bottle fed? If so, until what age:__________________________
Were there issues breastfeeding? ____
Does your child have any difficulty speaking or understanding at their age level?____

Allergies: *Please check all that apply (if yes, please explain reaction)*

- ☐ Acetaminophen/Tylenol _______________________________________
- ☐ Aspirin ____
- ☐ Erythromycin ____
- ☐ Fluoride ____
- ☐ Food/nuts/gluten/dyes ____
- ☐ Ibuprofen/Motrin/Advil ____
- ☐ Iodine ____
- ☐ Latex ____
- ☐ Local anesthetics ____
- ☐ Metals/Silver ____
- ☐ Penicillins/Amoxicillin ____
- ☐ Seasonal/Hay fever ____
- ☐ Sulfa ____
- ☐ Tetracycline ____
- ☐ **Other**____

Does your child have an epipen? Y/N

Medical Conditions:

Does your Child have any of the following conditions diagnosed or suspected (if yes, explain)?

- ☐ Abnormal/excessive bleeding ____
- ☐ AIDS/HIV ____
- ☐ Anemia ____
- ☐ Anxiety ____
- ☐ Asthma ____
- ☐ Autism____
- ☐ Autoimmune disease ____

- ☐ Blood disease/blood transfusions ____________________
- ☐ Breathing/respiratory disease ____________________
- ☐ Cancer (chemo/radiation) ____________________
- ☐ Cardiac conditions/heart valve conditions: ____________________
- ☐ Chronic Pain ____________________
- ☐ Diabetes ____________________
- ☐ Eating disorders ____________________
- ☐ Epilepsy/dizziness/fainting/seizures ____________________
- ☐ Fear of needles ____________________
- ☐ Frequent headaches/migraines ____________________
- ☐ Gastrointestinal disease ____________________
- ☐ Acid Reflux ____________________
- ☐ Eye problems/ Glaucoma ____________________
- ☐ Hearing difficulties ____________________
- ☐ Heart murmur ____________________
- ☐ Heart rhythm disorder ____________________
- ☐ Hemophilia ____________________
- ☐ Hepatitis/liver disease ____________________
- ☐ Joint replacement ____________________
- ☐ Kidney disease/problems ____________________
- ☐ Malnutrition/vitamin deficiency ____________________
- ☐ Multiple sclerosis ____________________
- ☐ Neurological disorders ____________________
- ☐ Pacemaker ____________________
- ☐ Persistent swollen glands in neck ____________________
- ☐ Physical challenges ____________________
- ☐ Pregnant ____________________
- ☐ Requires premedication for dentistry Y or N, ____________________
- ☐ Psychiatric care ____________________
- ☐ Sleep apnea____________________
- ☐ STD's____________________
- ☐ Sinus trouble ____________________
- ☐ Syndromes____________________
- ☐ Systemic Lupus____________________
- ☐ Thyroid problems ____________________
- ☐ Tuburculosis ____________________
- ☐ Tumors or Growths ____________________
- ☐ Ulcers ____________________
- ☐ Wheelchair access required ____________________
- ☐ Other____________________

Has your child had any major changes to their general health in the last five years? (this includes hospitalizations, surgeries, etc.)

____

Medications:
Is your child currently taking any medications: Y or N, (if Y please list Drug name, dosage and number of times a day)

____
____
____
____
____

Dental History (if applicable)

Date of last dental visit:___________________________
Dentist Name/Office: ____
Were x-rays taken at your last visit? (Y/N)____
**If Xrays were recently taken please have the previous office email them to us for our records*
Were you referred to our office for a specific reason? (please elaborate)

____
____

- ☐ My child is in dental pain ____
- ☐ My child has had a negative dental experience in the past

  ____
  ____

Do you have any other dental concerns that you would like to be addressed at the next visit?

____
____
____

-------------------------------*Please sign and date below*—---------------------------------

******By signing this form I agree that the information provided in this form is correct to the best of my knowledge***

____   _____________________

Signature   *Date*