

MEDICAL/DENTAL HISTORY

PATIENT'S NAME _____	<input type="checkbox"/> M <input type="checkbox"/> F	AGE _____	BIRTHDATE _____	TODAY'S DATE _____
PHYSICIAN'S NAME AND PHONE NUMBER _____			DATE OF LAST PHYSICAL EXAM _____	

WHO MAY WE THANK FOR THIS REFERRAL? _____

IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO IF SO, WHY? _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO IF SO, WHEN AND WHY? _____

ALLERGIES _____ ALLERGIES TO _____
 MEDICATIONS _____

DOES YOUR CHILD DEVELOP RASH, HIVES, SWELLING OR EYE IRRITATION AFTER TOUCHING A BALLOON, RUBBER GLOVES, ETC.: YES NO

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? YES NO IF YES, PLEASE LIST MEDICATIONS _____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- | | | | | | | | |
|----------------------------|----------------------------|----------------------------|---------------------------------|-------------------------------|----------------------------|----------------------------|---------------------------------|
| Anemia | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | HIV/AIDS | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Asthma | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Hyperactivity/ADHD | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Autism | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Kidney Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Birth Defects | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Learning Disabilities | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Bleeding Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Liver Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Blood Disorders | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Mental Retardation | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Blood Transfusions | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Muscular Dystrophy | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Cancer | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Pregnant | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Cerebral Palsy | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Psychiatric Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Chronic Ear Infections | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Radiation Therapy | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Cystic Fibrosis | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Rheumatic Fever | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Delayed Speech Development | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Seizures | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Developmental Delay | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Sexually Transmitted Diseases | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Diabetes | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Sickle Cell Anemia | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Down's Syndrome | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Skin Disorders | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Emotional Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Sleep Apnea | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Epilepsy | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Snoring | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| G-Tube Feeding | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Spina Bifida | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Hearing Loss/Impairment | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Tuberculosis | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Heart Condition/Murmur | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Tumors | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Hepatitis | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | X-ray Treatment (not dental) | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE |
| Herpes | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | Syndrome (specify) _____ | | | |
| High Blood Pressure | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> UNSURE | | | | |

PLEASE EXPLAIN ALL "YES/UNSURE" RESPONSES AND ANY OTHER PROBLEMS/CONDITIONS YOUR CHILD MAY HAVE: _____

DENTAL HISTORY

FAMILY DENTAL HISTORY MISSING/EXTRA TEETH DECAY UNDERBITE/OVERBITE/JAW SURGERY OTHER _____

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? YES NO IF NO, DATE OF LAST DENTAL EXAMINATION _____

IS THIS AN EMERGENCY VISIT? YES NO IF YOUR CHILD IS HAVING A DENTAL PROBLEM, PLEASE SPECIFY: _____

HOW DO YOU THINK YOUR CHILD WILL REACT TO THIS DENTAL VISIT? COOPERATIVE UNCOOPERATIVE NOT SURE

PLEASE EXPLAIN YOUR RESPONSE _____

IF YOUR CHILD HAS SEEN A PREVIOUS DENTIST, PLEASE LIST THE NAME AND PHONE NUMBER BELOW _____

SIGNATURE PARENT/GUARDIAN _____ DATE _____