



### Patient Medical Health History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Pediatrician/Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_

**Current medications:**  None  List: \_\_\_\_\_

**Allergies (food/drug/latex):**  None  List: \_\_\_\_\_

Has the patient ever had any of the following conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anxiety / Depression              | <input type="checkbox"/> Cerebral Palsy             | <input type="checkbox"/> Intellectual Disability  |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Congenital Birth Defects   | <input type="checkbox"/> Kidney Problems          |
| <input type="checkbox"/> Abnormal Bleeding/Bruising        | <input type="checkbox"/> Congenital Heart Defects   | <input type="checkbox"/> Organ transplant         |
| <input type="checkbox"/> Acid Reflux / GI Problems         | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Any Operations           |
| <input type="checkbox"/> ADD / ADHD                        | <input type="checkbox"/> Eating Disorder            | <input type="checkbox"/> Physical Disability      |
| <input type="checkbox"/> Artificial Joints or Heart Valves | <input type="checkbox"/> Fainting spells            | <input type="checkbox"/> Seizures/Epilepsy        |
| <input type="checkbox"/> Autism / ASD                      | <input type="checkbox"/> Hearing Impairment         | <input type="checkbox"/> Sickle Cell Anemia       |
| <input type="checkbox"/> Autoimmune Disease                | <input type="checkbox"/> High / low blood pressure  | <input type="checkbox"/> Snoring/Sleep Apnea      |
| <input type="checkbox"/> Blood Disorders                   | <input type="checkbox"/> Hepatitis/Liver Conditions | <input type="checkbox"/> Tonsils/Adenoids removed |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Tuberculosis             |

Please elaborate on any of the above or list any other health problems/special concerns: \_\_\_\_\_

### Patient Dental History

Previous Dentist/Office Name (if applicable): \_\_\_\_\_

Is the patient taking supplemental fluoride tablets/drops?      Y      N  
 Has your child been evaluated by an orthodontist?      Y      N      With whom: \_\_\_\_\_

Additional comments regarding your child's dental history: \_\_\_\_\_

I have read and understand the above questions and have answered them to the best of my ability. If there are any changes to the patient's health status, I will inform the dentist and staff.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_