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?

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

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