CHILD'S MEDICAL HISTORY

DATE OF BIRTH_____AGE_____

PLEASE CIRCLE

IS YOUR CHILD HAVING DENTAL PAIN OR DISCOMFORT AT THIS TIME? YES NO

DOES YOUR CHILD FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES NO

HAS YOUR CHILD EVER HAD A BAD EXPERIENCE IN THE DENTAL OFFICE? YES NO

HAS YOUR CHILD BEEN HOSPITALIZED OR BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE LAST TWO YEARS? YES NO

IF YES, PLEASE DESCRIBE_____

_____

DOES YOUR CHILD TAKE ANY PRESCRIPTION DRUGS OR OVER THE COUNTER MEDICATION? YES NO

IF YES, PLEASE DESCRIBE_____

_____

IS YOUR CHILD ALLERGIC TO (SYMPTOMS LIKE ITCHING, RASH, SWELLING OF HANDS, FEET OR EYES) OR MADE SICK BY PENICILLIN, ASPIRIN, CODEINE, LATEX, OR ANY OTHER DRUGS OR MEDICATIONS? YES NO

IF YES, PLEASE DESCRIBE_____

_____

HAS YOUR CHILD EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? YES NO

IF YES, PLEASE DESCRIBE_____

_____

DOES YOUR CHILD HAVE ANY OTHER MEDICAL OR DENTAL CONDITIONS THAT YOU ARE AWARE OF? YES NO

IF YES, PLEASE DESCRIBE_____

_____

IS THERE ANY OTHER INFORMATION THAT YOU WOULD LIKE TO SHARE?

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TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF MY CHILD HAS ANY CHANGES IN HEALTH OR MEDICATIONS, I WILL INFORM THE STAFF AT THIS OFFICE AT THE NEXT APPOINTMENT.

_____ _____

DATE **SIGNATURE OF PARENT OR GUARDIAN**