CHILDREN'S DENTAL CENTER
MEDICAL HISTORY

Patient Name _____

Although dental personnel primarily treat the area in and around the mouth, the mouth is part of the entire body and often reflects the health of the rest of the body. Health problems or medications could have an important interrelationship with dental care. Thank you for answering the following questions.

Is your child under a physician's care now?_____
Has your child ever had a serious medical condition? _____
Has your child ever had surgery?_____
Has your child ever had a serious head or neck injury? _____
Is your child taking any medications?_____
Is it possible your child is pregnant?_____
Is your child on a special diet? _____

Is your child allergic to any of the following?
___Penicillin ___Aspirin ___Codeine ___Acryllic ___Metal ___Latex
___Local Anesthetic ___Other_____

Does your child have or have they ever had any of the following?

___AIDS/HIV	___Cleft Lip/Palate	___Hepatitis/Liver Disease
___Anemia	___Congenital Heart Lesion	___High Blood Pressure
___Arthritis	___Convulsions/Seizures	___Hyperactivity/ADHD
___Asthma	___Developmental Delay	___Kidney Disease
___Autism	___Diabetes	___Leukemia
___Bladder Condition	___Drug Addiction	___Mental Disability
___Blood Disease	___Epilepsy	___Mouth Sores
___Blood Transfusion	___Eye Problem	___Premature Birth
___Birth Defects	___Fainting/Dizziness	___Psychiatric Care
___Bone/Joint Prob.	___Fever Blisters	___Rheumatic Fever
___Brain Injury	___Growth/Development Prob.	___Sickle Cell Anemia
___Bruising Easily	___Heart Surgery	___Syndrome
___Cancer	___Headaches	___Tuberculosis
___Cerebral Palsy	___Hearing/Speech Impairment	___Other_____
___Chemotherapy	___Heart Murmur/Defect	___Child Abuse
___Hemophilia		

Comments:
_____
_____
_____

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays), and other diagnostic aids. I have given an accurate report of my child's physical and mental health and history. I have also reported any prior allergic or unusual reactions to drugs or anesthetics. I have reported any physical conditions that my child's physician has advised me should be reported to a dentist.

Signature	Relationship to Child	Date	Doctor's Signature
_____	_____	_____	_____