CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

CHILD'S NAME (Last, First, Middle): ______________________________

ADDRESS: ______________________________

PREFERRED NAME: ______________________ SEX: ______ DOB: ______________

PARENT/GUARDIAN: ______________________________ DATE: ______________

H PHONE: ______________ CELL: ______________ W PHONE: ______________

EMAIL: ______________________________

MEDICAL ALERTS: ______________________________

____

Date of Last Physical Exam:_____ / _____ / _________

Is child under a physician's care? _____Yes_____No

Reason: ______________________________

Have you observed any behavioral/psychological changes in your child? _____ Yes _____No

Explain: ______________________________

Has your child been diagnosed with any behavioral/psychological issues? (e.g., ADD, ADHD, Autism) ___ Yes ___ No

If yes, when?: ______________________________

Has child been a patient in a hospital or had any serious illness? _____ Yes _____ No

Explain: ______________________________

Does child have or has he/she ever had any of the following?:

YES	NO		YES	NO		YES	NO	
___	___	Arthritis	___	___	Hepatitis or Jaundice	___	___	Fainting Tendency
___	___	Rheumatic Fever	___	___	Liver Disease	___	___	Epilepsy
___	___	Heart Trouble	___	___	Cancer or Tumor	___	___	Thyroid Disease
___	___	Heart Murmur	___	___	Tuberculosis	___	___	Radiation Treatment
___	___	High/Low Blood Pressure	___	___	Diabetes	___	___	Mental Disorders
___	___	Chest Pain	___	___	Kidney/Bladder Trouble	___	___	HIV or AIDS
___	___	Stroke	___	___	Anemia	___	___	Prosthetic Replacement
___	___	Shortness of Breath	___	___	Lung Disease	___	___	Blood Transfusion
___	___	Asthma or hay Fever	___	___	Blood Disease	___	___	Latex Allergy
___	___	Sinus Trouble	___	___	Prolonged Bleeding			

Is child taking any of the following medications?:

YES	NO		YES	NO		YES	NO	
___	___	Cortisone Drugs	___	___	Ritalin	___	___	Blood Thinners
___	___	Steroids	___	___	Insulin	___	___	Sedatives

Is child taking any other medication?_____ Yes _____ No If yes, explain: ______________________________

Has child ever had an allergic reaction to any of the following?:

YES	NO		YES	NO		YES	NO	
___	___	Penicillin/Amoxicillin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Aspirin	___	___	Food	___	___	Other: ______________

Women Only:

Are you pregnant?____ Yes ____ No If yes: How many months?_________ Are you breast feeding?_________

Are you presently taking medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy, etc.)

Explain: ______________________________

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Responsible Party for Patient:

Name and Address: ______________________________

Signature: ______________________________

Please write any additional information on the back of this form. Thank you!