Medical History

In order to assure your child's safety, comfort and happiness during dental treatment, we need to obtain information from you. Please carefully and completely answer the questions below. Thank You.

PRINT:

Child's Name: _____ Age: _____

Date of Birth: _____ Sex: M F

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

If yes

Are you on a special diet? Yes No If yes _____

Do you use tobacco? Yes No If yes _____

Do you use Controlled substances? Yes No If yes _____

Women: Are you...

O Pregnant/Trying to get pregnant O Nursing? O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic

O Metal O Latex O Sulfa Drugs O Local Anesthetics

O If yes

Do you have, or have you had, any of the following:

AIDS/HIV Positive	O Yes O No	Arthritis/Gout	O Yes O No	Blood Transfusion	O Yes O No	Chest Pains	O Yes O No
Cortisone Medicine	O Yes O No	Epilepsy or Seizures	O Yes O No	Frequent Diarrhea	O Yes O No	Heart Attach/Failure	O Yes O No
Hemophilia	O Yes O No	High Cholesterol	O Yes O No	Leukemia	O Yes O No	Osteoporosis	O Yes O No
Radiation Treatments	O Yes O No	Scarlet Fever	O Yes O No	Stomach/Intestinal Disease	O Yes O No	Tuberculosis	O Yes O No
Alzheimer's Disease	O Yes O No	Artificial Heart Valve	O Yes O No	Breathing Problems	O Yes O No	Cold Sores/Fever Blisters	O Yes O No
Diabetes	O Yes O No	Excessive Bleeding	O Yes O No	Frequent Headaches	O Yes O No	Heart Murmur	O Yes O No
Hepatitis A	O Yes O No	Hives or Rash	O Yes O No	Liver Disease	O Yes O No	Pain in the Jaw Joints	O Yes O No
Recent Weight Loss	O Yes O No	Shingles	O Yes O No	Stroke	O Yes O No	Tumors or Growths	O Yes O No
Anaphylaxis	O Yes O No	Artificial Joint	O Yes O No	Bruise Easily	O Yes O No	Congenital Heart Disorder	O Yes O No
Drug Addiction	O Yes O No	Excessive Thirst	O Yes O No	Genital Herpes	O Yes O No	Heart Pacemaker	O Yes O No
Hepatitis B or C	O Yes O No	Hypoglycemia	O Yes O No	Low Blood Pressure	O Yes O No	Parathyroid Disease	O Yes O No
Renal Dialysis	O Yes O No	Sickle Cell Disease	O Yes O No	Swelling of Limbs	O Yes O No	Ulcers	O Yes O No
Anemia	O Yes O No	Asthma	O Yes O No	Cancer	O Yes O No	Convulsions	O Yes O No
Easily Winded	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Glaucoma	O Yes O No	Heart Trouble/Disease	O Yes O No
Herpes	O Yes O No	Irregular Heartbeat	O Yes O No	Lung Disease	O Yes O No	Psychiatric Care	O Yes O No
Rheumatic Fever	O Yes O No	Sinus Trouble	O Yes O No	Thyroid Disease	O Yes O No	Venereal Disease	O Yes O No
Angina	O Yes O No	Blood Disease	O Yes O No	Chemotherapy	O Yes O No	Yellow Jaundice	O Yes O No
Emphysema	O Yes O No	Frequent Cough	O Yes O No	Hay Fever	O Yes O No		O Yes O No
High Blood Pressure	O Yes O No	Kidney Problems	O Yes O No	Mitral Valve Prolapse	O Yes O No		O Yes O No
Rheumatism	O Yes O No	Spina Bifida	O Yes O No	Tonsillitis	O Yes O No		O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If Yes _____