MEDICAL HISTORY

Reset Form

Child's Name:_____Preferred Name?_____
Date of Birth:_____Age:_____Gender:_____Grade Level:_____School:_____
Pediatrician:_____Office phone:_____
Hobbies/Interests/Pets:_____Siblings Names and ages:_____

YES ☐ NO ☐ Is your child under the care of a physician for anything other than routine care?
If yes, please explain:_____

YES ☐ NO ☐ Does your child have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?
If yes, please circle which one. Who is the treating/diagnosing physician?_____

YES ☐ NO ☐ Does your child have any drug allergies or ever had a reaction to a DRUG or MEDICATION?
If yes, please list the drugs and the reaction:_____

YES ☐ NO ☐ Does/Did your child have allergies or a reaction to LATEX, FOODS, DYES, METALS, or ANYTHING ELSE?
If yes, please circle which & indicate if it's contact, airborne, or ingested, & explain:_____

YES ☐ NO ☐ Does your child take any medications on a regular basis?
If yes, please list:_____

YES ☐ NO ☐ Is your child taking any medications at this time that he/she does not normally take on a regular basis?
If yes, please list and explain:_____

YES ☐ NO ☐ Has your child EVER been a patient in a hospital or emergency room for ANY reason?
If yes, please list and explain:_____

YES ☐ NO ☐ Does your child or anyone in your family have a condition called methylenetetrahydroflate reductase deficiency (MTHFR) or hyperhomocysteinemia?

Please check any condition your child currently has or has ever had. If NONE apply then please check NONE.

☐ Asthma	☐ Bone Disorder	☐ Seizure/Epilepsy	☐ Reflux
Controlled?	☐ Skin Disorder	Last seizure?	☐ Fainting
Last attack?	☐ Premature Birth	What started seizure?	☐ POTS
What started attack?	☐ Low Birth Weight	☐ Cancer/Tumors	☐ Headaches
Inhaler with you?	☐ Failure to Thrive	☐ Leukemia	☐ Facial/Jaw Joint Pain
☐ Allergy	☐ Development/Mental Delay	☐ Hepatitis (A, B, C)	☐ Artificial Joint/Screw/Rod
☐ Breathing/Lung Problem	☐ Physical Challenge	☐ HIV/AIDS	☐ Pregnancy
☐ Diabetes	☐ Cerebral Palsy	☐ Tuberculosis	☐ Head/Mouth/Teeth Injury
☐ Endocrine Problem	☐ Brain Disorder	☐ Anemia	☐ Radiation/Chemotherapy
☐ Adrenal/Kidney Problem	☐ Eye/Ear Disorder	☐ Sickle Cell Trait/Disease	☐ ADD/ADHD
☐ Intestinal/Stomach Problem	☐ Nose/Throat Disorder	☐ Blood Transfusion	☐ Hyperactivity
☐ Liver Problem	☐ Cleft Lip/Palate	☐ Blood Disease	☐ Anxiety/Nervousness
☐ Heart Disease/Murmur	☐ Speech Problem	☐ Excessive Bleeding	☐ Autism/Asperger's
☐ High/Low Blood Pressure	☐ Feeding/Eating Problems	☐ Tonsils/Adenoids Removed	☐ Behavior/Psychiatric Issues
☐ Rheumatic Fever	☐ Neuromuscular Problems	☐ Tubes in Ears	☐ Learning Concerns
☐ Arthritis	☐ Congenital Birth Defect	☐ Sleep Apnea/Snoring	☐ NONE

If any of the above were checked, please explain:

_____

_____

YES ☐ NO ☐ Is there anything else you would like us to know or that we need to know about your child's health? If yes, please explain:

_____

_____

_____

The above medical/dental and medication history is complete and accurate to the best of my knowledge.
I will notify you of ANY change in the above prior to ANY appointment.
Signed (Parent/Guardian)_____Date: _____

DENTAL HISTORY

Child's Name:_____ Date of Birth:_____

What is the reason for your visit today: 1st Visit, Checkup, Discomfort, Habit, Orthodontics, Emergency, Other _____

YES ☐ NO ☐ Has your child ever seen a dentist before? If yes, by whom and approximately when? _____
YES ☐ NO ☐ Were X-rays taken? If yes, approximately when were the last X-rays taken?
YES ☐ NO ☐ Has your child had a traumatic medical or dental experience? If yes, please explain._____
YES ☐ NO ☐ Has your child ever injured any teeth or his/her mouth? If yes, please explain._____
YES ☐ NO ☐ Has your child ever experienced facial pain or had problems with the jaw joints near each ear?
YES ☐ NO ☐ Do you expect your child to be uncooperative?
YES ☐ NO ☐ Are you on well water?
YES ☐ NO ☐ Does your child drink NON-fluoridated water?
YES ☐ NO ☐ Does your child take fluoride tablets, drops or vitamins with fluoride?
YES ☐ NO ☐ Is your child a toothpaste eater?
YES ☐ NO ☐ Does your child suck his/her thumb, finger, pacifier, blanket, etc.?
YES ☐ NO ☐ Does your child grind his/her teeth?
YES ☐ NO ☐ Does your child go to sleep with a bottle? If yes, what's in the bottle?_____
YES ☐ NO ☐ Does your child have difficulty breathing through the nose with his/her mouth closed?
YES ☐ NO ☐ Is there anything else you would like us to know or that we need to know about your child's dental health?
If yes, please explain:

_____
_____
_____

The above medical/dental and medication history is complete and accurate to the best of my knowledge.
I will notify you of ANY change in the above prior to ANY appointment.
Signed (Parent/Guardian)_____Date:_____