Medical History

Physician's Name _____ Date of Last Visit _____

s the child taking any medications, vitamins or herbal supplements? _____ Yes _____ No

Please List:

a. _____

b. _____

c. _____

Does the child have any drug allergies or have an adverse reaction to any medication? __ Yes __ No _ Don't Know

Please specify: _____

				Reaction Type
Penicillin/Amoxicillin?	____ Yes	____ No	____ Don't Know	_____
Codeine?	____ Yes	____ No	____ Don't Know	_____
Anesthetics?	____ Yes	____ No	____ Don't Know	_____
Latex?	____ Yes	____ No	____ Don't Know	_____
Aspirin?	____ Yes	____ No	____ Don't Know	_____
Other?	____ Yes	____ No	____ Don't Know	_____

Has the child ever responded adversely to medical or dental treatment? __ Yes ___ No ___ Don't Know

What is the child's weight? _____

Has the child ever bled excessively? _____ __ Yes ___ No ___ Don't Know

Does the child smoke or use any tobacco products? __ Yes ___ No ___ Don't Know

Does the child drink alcohol? (If yes, please indicate how many drinks per week) __ Yes ___ No ___ Don't Know

Does the child have anything artificial (pins, screws, valves, etc.) implanted in their body? __ Yes ___ No ___ Don't Know

Has the child ever had a reaction to any type of metal? __ Yes ___ No ___ Don't Know

Has the child ever been told that they need antibiotics before dental treatment? __ Yes ___ No ___ Don't Know

Has the child had any type of surgery? Please List: _____ __ Yes ___ No ___ Don't Know

_____

Does the child snore or have sleep apnea? __ Yes ___ No ___ Don't Know

Does the child have any other diagnosed conditions? __ Yes ___ No ___ Don't Know

(Developmental, Genetic, Psychiatric, Physical)

If so, explain _____

Has the child ever had head or neck radiation? __ Yes ___ No ___ Don't Know

Females: Do you suspect the child may be pregnant? __ Yes ___ No ___ Don't Know

If the child has given birth, is she nursing? __ Yes ___ No ___ Don't Know

Has the child ever had any of the following conditions? Please circle all that apply.

Infective Endocarditis	Blood Disease	Internal Shunts	Kidney Disease	Asthma
Heart Transplant	Stomach Ulcers	Stroke	Venereal Disease	Tuberculosis
Heart Attack	Immune Disorders	Lung Disease	Tumors/Growths	Hemophilia
Congenital Heart Problems	Unusual Numbness	Liver Disease	Blood Transfusion	Epilepsy
Artificial Joints	AIDS/HIV	Chemical Dependency	Cancer	Fainting Spells/Seizures
Heart Disease/Conditions	Artifcial Heart Valves	Hepatits A B C D	Diabetes	
High/Low Blood Pressure	Enlarged Heart			

Notes _____

_____

_____

_____

Parent/GuardianSignature _____ Date _____