Family & Cosmetic Dentistry
Raymond Ferri, D.D.S., & Patrick Lawrence, D.D.S., P.A.

Child's Medical History

Child's Name:	**Age:**
Parent/Guardian:	
Child's Physician and their specialty:	
Phone Number:	**Most Recent examination:**
Purpose:	

What is your child's general health?
❑ Excellent ❑ Good ❑ Fair ❑ Poor

Is the Child currently under the care of a physician
❑ Yes ❑ No

If yes, describe:

Has the child ever had any of the following?

Abnormal bleeding	❑ Yes	❑ No	**Anemia**	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	**Blood Transfusion**	❑ Yes	❑ No
Cancer/Chemotherapy	❑ Yes	❑ No	**Chicken Pox**	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No	**Diabetes**	❑ Yes	❑ No
Difficulty Breathing	❑ Yes	❑ No	**Epilepsy**	❑ Yes	❑ No
Fainting Spells	❑ Yes	❑ No	**Frequent Headaches**	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No	**Hearing Impaired**	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	**Heart Surgery**	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No	**Hepatitis**	❑ Yes	❑ No
Herpes/Fever Blisters	❑ Yes	❑ No	**HIV+ / AIDS**	❑ Yes	❑ No
Hospital Stay	❑ Yes	❑ No	**Joint Replacement**	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	**Learning Disabilities**	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No	**Mitral Valve Prolapse**	❑ Yes	❑ No
Operations	❑ Yes	❑ No	**Psychiatric Problems**	❑ Yes	❑ No
Radiation Treatment	❑ Yes	❑ No	**Rheumatic Fever**	❑ Yes	❑ No
Seizures	❑ Yes	❑ No	**Sickle Cell Disease**	❑ Yes	❑ No
Sinus Problems	❑ Yes	❑ No	**Tuberculosis (TB)**	❑ Yes	❑ No

Please list any other medical conditions that the child has ever had

Is the child allergic to any of the following?

Aspirin	❑ Yes	❑ No	**Codeine**	❑ Yes	❑ No
Dental Anesthetic	❑ Yes	❑ No	**Erythromycin**	❑ Yes	❑ No
Latex	❑ Yes	❑ No	**Penicillin**	❑ Yes	❑ No
Tetracycline	❑ Yes	❑ No	**Other**	❑ Yes	❑ No

If Other please explain:

Please list all prescriptions / over-the-counter medications that the child is currently taking:

Please list any other medications/food that the child is allergic to:

Anything you would like to discuss with the Doctor in private?
❑ Yes ❑ No

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN THE CHILD'S MEDICAL HISTORY OR ANY MEDICATIONS THE CHILD MAY BE TAKING

Parent/Guardian Signature:
I agree that the above field represents my signature. ❑
Date: