Family & Cosmetic Dentistry
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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?

Condition			Condition		
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?

Allergen			Allergen		
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:
Date: