

Medical History

Physician's Name _____ Date of Last Visit _____

Is 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 medications? ___ 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

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	Artificial Heart Valves	Hepatitis A B C D	Diabetes	
High/Low Blood Pressure	Enlarged Heart			

Notes _____

Parent/Guardian Signature _____ Date _____