Record Number	
Patient Name (Last, First, MI)	
Date of Birth	Patient Phone

MEDICAL INFORMATION

If "**YES**" to any of the following items or if you are unsure, please explain below

GROWTH AND DEVELOPMENT	Yes	No
1. Were there any complications during pregnancy or was child premature at birth?	☐	☐
2. Has child had psychological counseling or is counseling being considered for the near future?	☐	☐
3. Any learning, behavioral, excessive nervousness, or communication problems?	☐	☐
4. Any problems with physical growth?	☐	☐
CENTRAL NERVOUS SYSTEM		
5. Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	☐	☐
6. Any history of injury to the head?	☐	☐
7. Any sensory disorders? (Seeing, Hearing)	☐	☐
CARDIOVASCULAR SYSTEM		
8. Any history of congenital heart disease, heart murmur or other heart damage (e.g. rheumatic fever)?	☐	☐
9. Has any heart surgery been done or recommended?	☐	☐
10. Any history of chest pains or high blood pressure?	☐	☐
HEMATOPOIETIC AND LYMPHATIC SYSTEMS		
11. Has your child ever had a blood transfusion or blood products transfusion?	☐	☐
12. Any history of anemia or sickle cell disease?	☐	☐
13. Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts?	☐	☐
14. Is your child more susceptible to infections than other children are?	☐	☐
15. Is there any history of tender or swollen lymph nodes or glands?	☐	☐
RESPIRATORY SYSTEM		
16. Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing?	☐	☐

GASTROINTESTINAL SYSTEM	Yes	No
17. Any history of stomach, intestinal, or liver problems?	☐	☐
18. Any history of hepatitis or jaundice?	☐	☐
19. Any history of eating disorders, such as anorexia nervosa (binge/purge) or bulimia (binge)?	☐	☐
20. Any history of unusual weight loss/gain?	☐	☐
GENITOURINARY SYSTEM		
21. Any history of urinary tract infections, bladder, or kidney problems?	☐	☐
22. Is the patient pregnant or possibly pregnant?	☐	☐
ENDOCRINE SYSTEM		
23. Any history of diabetes?	☐	☐
24. Any history of thyroid disorders or other glandular disorders?	☐	☐
SKIN		
25. Any history of skin problems?	☐	☐
26. Any history of cold sores (herpes) or canker sores (aphthae)?	☐	☐
EXTREMITIES		
27. Any limitations of use of arms or legs?	☐	☐
28. Any arthritis or other joint problems?	☐	☐
29. Any problems with muscle weakness or muscular dystrophy?	☐	☐
ALLERGIES		
30. Is your child allergic to any medications?	☐	☐
31. Any hay fever, hives, or skin rashes caused by allergies?	☐	☐
32. Any other allergies?	☐	☐

Explanation:

MEDICATIONS OR TREATMENTS Is your child currently taking any medication (prescription or non-prescription medicine)? Yes ☐ No ☐

If yes, Medication(s): _____ Dosage _____ Time Per Day _____

_____ _____ _____

_____ _____ _____

HOSPITALIZATIONS Has your child ever been hospitalized? Yes ☐ No ☐

_____ (Hospital) _____ (Date) _____ (Reason)

IMMUNIZATIONS Is your child presently protected by immunization against DPT [diptheria, whooping cough (pertussis), tetanus], polio, measles, mumps, and German measles (rubella)? Yes ☐ No ☐

Please check any of the following that your child has now, has recently been exposed to, or has had in the past:

	Yes	No
Immune deficiency diseases including HIV/AIDS	☐	☐
Chicken pox (varicella)	☐	☐
Earache (otitis)	☐	☐
Eye infection (conjunctivitis)	☐	☐
German measles or 3-day measles (rubella)	☐	☐
Glandular fever or mono (infectious mononucleosis)	☐	☐
Measles (rubeola)	☐	☐
Mumps (parotitis)	☐	☐
Scarlet fever (scarlatina)	☐	☐
Sore throat (tonsillitis or pharyngitis)	☐	☐
Substance abuse, alcoholism, drug addition	☐	☐
Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, or tonsillitis)	☐	☐
Sexually transmitted diseases	☐	☐

ORAL HEALTH HISTORY

	Yes	No
Does your child have a toothache or other immediate dental problem?	☐	☐
Has your child ever had a toothache?	☐	☐
Has your child had any injury to the mouth, teeth, or jaws (fall, blow, etc.)?	☐	☐
If this your child's first dental visit?	☐	☐

If no: Date _____
Dentist _____
Reason _____

Has your child ever had an unfavorable dental experience?	☐	☐
Is (was) your child nourished by nursing beyond one year of age?	☐	☐

If yes, check: Breast _____ Nursing Bottle ____
To what age? _____

Does your child eat a well-balanced diet?	☐	☐

If no, what foods or food groups are not adequate?
_____

Does (or has) your child have (or had) sucking habit beyond one year of age?	☐	☐

If yes, check: Thumb(s) _____ Finger(s) _____
Pacifier _____ Other _____

Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks?	☐	☐
Does (or has) your child have (or had) any other oral habits beyond one year of age?	☐	☐

If yes, check: Lip Biting _____ Mouth Breathing _____
Nail Biting _____ Teeth Grinding _____ Other _____

Please explain if you answered "YES" to, or are uncertain about, any of the above items: _____
_____
_____

How often is tooth brushing performed? _____ time(s) per _____	☐	☐
Does your child use dental floss?	☐	☐
Does someone assist your child with brushing and cleaning the teeth?	☐	☐
Does someone inspect for thoroughness after the procedure?	☐	☐
Does your child use a fluoride toothpaste?	☐	☐
Has your child ever had a fluoride treatment?	☐	☐
Has your child ever taken a fluoride supplement or vitamins with fluorides?	☐	☐

Drinking water source:
City water supply ___ Name of City _____
Private well or other than city ___ Has a fluoride analysis been done? ___ Date of analysis _____ Fluoride content _____

Father's Name _____ Age _____ Marital Status:

Mother's Name _____ Age _____ S M W D Sep

Brothers (names and ages) _____

Sisters (names and ages) _____

Pets _____ Hobbies _____

Reason for visit: _____

Referring Dentist/Physician _____
(name) (address) (phone number)

To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature - Patient (or parent/guardian if patient is under age 18) Date

MEDICAL/DENTAL HEALTH UPDATE - Please verify changes in your health status at regular intervals.

Date	Change in Health Status	Signature
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____