

# PATIENT HISTORY & INFORMATION ( for children up to age 18 )

## MEDICAL HISTORY

Child's name: \_\_\_\_\_

Physician's name: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

Last consultation/visit with a physician? \_\_\_\_\_ Reason: \_\_\_\_\_

Last physical examination? \_\_\_\_\_ Results: \_\_\_\_\_

Been a patient in a hospital in the past 5 years:  Yes  No Reason: \_\_\_\_\_

Had any serious illness or operations?  Yes  No Type: \_\_\_\_\_

Have now, or ever had, any of the following (Please check and describe fully under remarks):

- |   |                          |                          |   |                          |                          |                                    |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| 1. Heart Disease . . . . .                | <input type="checkbox"/> | <input type="checkbox"/> | 14. Persistent Swollen Glands . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | 27. Jaundice . . . . .             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure . . . . .          | <input type="checkbox"/> | <input type="checkbox"/> | 15. Psychiatric Treatment               | <input type="checkbox"/> | <input type="checkbox"/> | 28. Hepatitis, A, B or C . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood Disorder – Anemia . . . . .      | <input type="checkbox"/> | <input type="checkbox"/> | 16. Arthritis                           | <input type="checkbox"/> | <input type="checkbox"/> | 29. Chronic Headache . . . . .     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Rheumatic Fever . . . . .              | <input type="checkbox"/> | <input type="checkbox"/> | 17. Night Sweats                        | <input type="checkbox"/> | <input type="checkbox"/> | 30. Ringing in the Ears . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Heart Murmur                           | <input type="checkbox"/> | <input type="checkbox"/> | 18. Persistent Cough                    | <input type="checkbox"/> | <input type="checkbox"/> | 31. Allergies                      |                          |                          |
| 6. Artificial Joints or Device . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | 19. Tumor History                       | <input type="checkbox"/> | <input type="checkbox"/> | a. Penicillin                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Heart Valve Damage or Surgery          | <input type="checkbox"/> | <input type="checkbox"/> | 20. Chemotherapy                        | <input type="checkbox"/> | <input type="checkbox"/> | b. Other Antibiotics               | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Chest Pain                             | <input type="checkbox"/> | <input type="checkbox"/> | 21. Radiation Treatment                 | <input type="checkbox"/> | <input type="checkbox"/> | c. Codeine, Aspirin                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Thyroid Disease, Hyperthyroidism . . . | <input type="checkbox"/> | <input type="checkbox"/> | 22. Immune System Disorder              | <input type="checkbox"/> | <input type="checkbox"/> | d. Local Aneshtetic, Novacain      | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Diabetes                              | <input type="checkbox"/> | <input type="checkbox"/> | 23. AIDS, ARC or HIV Infection          | <input type="checkbox"/> | <input type="checkbox"/> | e. Latex                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Stroke                                | <input type="checkbox"/> | <input type="checkbox"/> | 24. Sinus Trouble                       | <input type="checkbox"/> | <input type="checkbox"/> | f. Others                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Epilepsy or Siezures                  | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ulcers                              | <input type="checkbox"/> | <input type="checkbox"/> | 32. Asthma                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Fainting                              | <input type="checkbox"/> | <input type="checkbox"/> | 26. Liver or Kidney Disease             | <input type="checkbox"/> | <input type="checkbox"/> | 33. Tuberculosis, Emphysema        | <input type="checkbox"/> | <input type="checkbox"/> |

Had excessive bleeding requiring treatment?  Yes  No

Taking any medicines, drugs or pills?  Yes  No If yes, what? \_\_\_\_\_

Have any disease or problem not listed above? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

Does or has your child:

1. Experienced any unfavorable reactions to previous dental treatments? ?  Yes  No

2. Have gums that bleed when brushed? . . . . .  Yes  No

3. Chew properly and without pain? . . . . .  Yes  No

4. Brush teeth daily? . . . . .  Yes  No

5. Is Fluoride being taken daily? . . . . .  Yes  No

6. Had or need orthodontic treatment? . . . . .  Yes  No

7. Have stains or discoloration on teeth? . . . . .  Yes  No

8. Require premedication prior to dental treatment? . .  Yes  No

9. Name of former dentist: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

10. Please note any special dental concerns that bring you to our office: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent (or Guardian Signature) \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date: \_\_\_\_\_