PEDIATRIC DENTAL ASSOCIATES
MEDICAL HISTORY

Patients Name_____Date of Birth_____

Name of Pediatrician_____

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of your entire body. Health problems that the patient may have, or medication that the patient may be taking, could have an important interrelationship with the dentistry the patient will receive. Thank you for answering the following questions

Is patient under a physician's care now? (other than routine)	Yes	No	If yes, please explain:_____
Has patient ever been hospitalized or had a major operation?	Yes	No	If yes, please explain:_____
Has patient ever had a serious head or neck injury?	Yes	No	If yes, please explain:_____
Is patient taking any medication, pill, or drugs?	Yes	No	If yes, please explain:_____
Is patient on a special diet?	Yes	No	If yes, please explain:_____
Does patient use tobacco?	Yes	No	

Is female patient… *please circle*

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Is patient allergic to any of the following? *please circle*

Aspirin Penicillin Codeine Metal Latex Sulfa Drugs Local Anesthetic

Other (including food) Please explain:_____

Do patient have, or have had, any of the following? *please circle*

AIDS/HIV positive	ADD/ADHD	Anaphylaxis	Anemia	Artificial Heart Valve
Asthma	Autism	Blood Disease	Blood Transfusion	Bruise Easily
Cancer	Chemotherapy	Cleft Palate	Cold/Sores/Fever Blisters	Congenital Heart Disorder
Cortisone Medicine	Diabetes	Down's Syndrome	Drug Addiction	Epilepsy or Seizures Disorder
Excessive Bleeding	Fainting Spells/Dizziness	Excessive Bleeding	Fainting/Dizziness	Fetal Alcohol Syndrome
Frequent Cough	Frequent Headaches	Febrile Seizures	Heart Murmur	Hemophilia
Hepatitis A	Hepatitis B or C	High Blood Pressure	Hives or Rash	Hypoglycemia
Irregular Heartbeat	Kidney Problems	Leukemia	Liver Disease	Low Blood Pressure
Lung Disease	Pain in Jaw Joints	Psychiatric Care	Radiation Treatment	Renal Dialysis
Rheumatic Fever	Scarlet Fever	Sensory Processing Disorder	Shingles	Sickle Cell Disease
Sinus Trouble	Spina Bifida	Stomach/Intestinal Disease	Thyroid Disease	Tonsillitis
Tumors or Growths	Ulcers	Visually Impaired	Yellow Jaundice	

Does patient have any medical conditions not listed above? Yes No If yes, please explain:_____

Comments_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform this dental office of any changes in medical status of the patient.

PRINTED NAME_____RELATIONSHIP TO PATIENT_____

SIGNATURE_____DATE_____