For Ages 12 and under

Doctor Signature:_______________

Medical and Dental History Form *Please complete the following form so we may better serve your child*

Child's Name:______________________________ Date of Birth:____________ Gender: _________________

What is the main reason you brought your child to us today? Weight:______________

Has your child ever had any of the following?	Yes	No	Comments
Heart Murmur			
Congenital heart disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular, or other Endocrine Disease			
Liver Disease/Hepatitis/Jaundice			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures/Convulsions/Loss of Consciousness			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Cancer			
Speech disorder			
Hearing disorder			
Sight or eye disorder			
Frequent Headaches			
Mental, Emotional, or Developmental delays			
Autism, ADHD, Genetic Disorder/ Syndrome (please note)			
Frequent infections			
Has your child ever received blood/blood products?			
Has your child ever been hospitalized?			
Has your child ever been seriously ill?			
Has your child ever had any significant injury?			
Has you child ever had surgery?			
Does your child have tonsillar enlargement or snoring?			
Does your child clench or grind their teeth?			
Which medicines does your child take at this time?			please list
Is your child allergic to any medicines?			please list
Is your child allergic to any food, environ pollutants, animal?			please list

Are there any other problems, disease, or medical condition that we should know about in order to care for your child? If so, please list here:

Who is your child's Primary Physician or Physician Group? Please name and phone number here:

Does your child have any of the following:	Yes	No	Comments
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck or other oral habit			
Does your child have any other dental condition			

How do you think your child will cooperate for this appointment? Well-behaved Unsure Uncooperative

Which of the following categories best describes your child's learning abilities? Delayed Normal Advanced

Parent/Guardian Signature:______________________________________Date:_______________ Reviewed by:___________