



# MEDICAL AND HEALTH HISTORY

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Tel. \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

- |  |   |
|--|---|
| <p>1. Is child under care of physician now? _____ <input type="checkbox"/> <input type="checkbox"/><br/>Name of Dr. _____</p> <p>2. Is child receiving any medication or drugs? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>3. Is child taking any herbal supplements? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>4. Is there any excessive bleeding when cut? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>5. Any bleeding disorders in the family? _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Has child ever been hospitalized? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>7. Has child ever had surgery? _____ <input type="checkbox"/> <input type="checkbox"/><br/>Reason: _____</p> <p>8. Is there any allergy to penicillin or other drugs? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> | <p>9. Are there other allergies? latex-food-pollen-animals- dust-other? _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Does child have good physical coordination? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>11. Are there any physical problems? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>12. Any learning difficulties? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>13. Does child get upset easily? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>14. Any problems at birth/before birth? _____ <input type="checkbox"/> <input type="checkbox"/><br/>_____</p> <p>15. Immunizations current? _____ <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|

**HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:**

- |   |  |   |                                       |  |
|---|--|---|---------------------------------------|--|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Chronic Sinus       | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Hearing              | <input type="checkbox"/> Liver        | <input type="checkbox"/> Strep Throat    |
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart / Heart Murmur | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Mastoid      | <input type="checkbox"/> Transfusions    |
| <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Fainting            | <input type="checkbox"/> High Fever           | <input type="checkbox"/> Measles      | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Other           |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of: \_\_\_\_\_  
\_\_\_\_\_

YES    NO

May we request release of your child's medical records for our reference \_\_\_\_\_

**PERMIT FOR TREATMENT UPON A MINOR**

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor.

Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: \_\_\_\_\_  
(signature and relationship to patient)

**SUMMARY:** (for doctor's use)