

Pediatric Medical History

Child's Full Name: _____ Nickname: _____ Date of birth: ___/___/___
 Gender: M F Race/Ethnicity: _____ Height: _____ Weight: _____ Date of last physical examination: _____
 Name/address/phone of primary physician: _____
 Name/address/phone of medical specialists: _____

- Is your child being treated by a physician at this time? Reason _____ YES NO
 Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? YES NO
 List name, dose, frequency & date started: _____
 Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? YES NO
 List date & describe: _____
 Has your child ever had a reaction to or problem with an anesthetic? Describe _____ YES NO
 Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ YES NO
 Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ YES NO
 Is your child up to date on immunizations against childhood diseases? YES NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

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| Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Problems with physical growth or development | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sinusitis, chronic adenoid/tonsil infections | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sleep apnea/snoring, mouth breathing, or excessive gagging | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Irregular heart beat or high blood pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma, reactive airway disease, wheezing, or breathing problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cystic fibrosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Frequent colds or coughs, or pneumonia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Frequent exposure to tobacco smoke | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Jaundice, hepatitis, or liver problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bladder or kidney problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rash/hives, eczema or skin problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Impaired vision, hearing, or speech | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Developmental disorders, learning problems/delays, or intellectual disability | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cerebral palsy, brain injury, epilepsy, or convulsions/seizures | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Autism/autism spectrum disorder | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Behavioral, emotional, communication, or psychiatric problems/treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Abuse (physical, psychological, emotional, or sexual) or neglect | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes, hyperglycemia, or hypoglycemia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Precocious puberty or hormonal problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Thyroid or pituitary problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Anemia, sickle cell disease/trait, or blood disorder | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hemophilia, bruising easily, or excessive bleeding | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Transfusions or receiving blood products | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO |

PROVIDE DETAILS HERE: _____

- Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? YES NO
 If YES, describe _____
