MEDICAL HISTORY

Child's Family Doctor: ______________________ Child's Family Dentist: ______________________

Phone # ______________________ Phone # ______________________

Has your child had any of the following: (Please check any that apply)

❑ Allergies Specify: ______________________

❑ Arthritis	❑ Fainting Spells	❑ Kidney Disease	❑ Special Schooling
❑ Asthma	❑ Headaches	❑ Leukemia	❑ Speech Problems
❑ Bed-wetting	❑ Hearing Impaired	❑ Measles	❑ Visually Impaired
❑ Bleeding Disorder	❑ Heart Disease	❑ Mumps	❑ Other - Please Specify
❑ Cerebral Palsy	❑ Hepatitis	❑ Psychiatric Disorder	______________
❑ Diabetes	❑ HIV or AIDS	❑ Rheumatic Fever	❑ No Medical Concerns
❑ Epilepsy	❑ Jaundice		______________ Initial

1. Is your child presently taking any medication? ❑ Yes ❑ No

   If yes, please specify: ______________________

2. Has your child ever had a reaction to any drugs? ❑ Yes ❑ No

   If yes, please specify: ______________________

3. Has your child ever been in a hospital? ❑ Yes ❑ No

   If yes, please specify: ______________________

4. Has your child suffered any physical, sexual or mental abuse? ❑ Yes ❑ No

5. What is your child's normal bedtime? ______________________

6. What is your child most interested in? ______________________

7. Is your child involved in any sport activities? ❑ Yes ❑ No

   Which ones?: ______________________

8. Do you consider your child to be:

   ❑ Advanced in the learning process ❑ Progressing normally ❑ Slow learner

9. How would you describe your child? (Check all that apply)

   ❑ Shy ❑ Outgoing ❑ Emotional ❑ Active ❑ Low Self Esteem ❑ High Self Esteem

10. How would you rank your personal anxiety in a dental environment?

    ❑ High ❑ Moderate ❑ Low

I have read and completed this medical history on behalf of my child. I understand that to ensure the best possible treatment for my child, I must update Pediatric Dentistry of any changes to my child's medical/physical condition.

Date: ______________________ Signature of Parent or Guardian: ______________________