*Medina Pediatric Dentistry Patient Medical History Form*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Although dental personnel treat the mouth of patients, your mouth is a part of your body that needs care as well. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.*

Are you under a physician’s care now? \_\_\_\_\_Yes \_\_\_\_\_No if yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had major operations? \_\_\_\_\_Yes\_\_\_\_\_ No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on any medications, pills, or drugs? \_\_\_ Yes\_\_\_ No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History:**

Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_ Do you assist with brushing or flossing?

Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_ Has your child ever had an injury involving the teeth?

Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_ Pacifier/ Thumb or Finger sucking?

Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_ Grinding teeth?

 **Please check Yes or No if your child has any of the following:**

ADHD: Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_ AIDS/HIV: Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_ Kidney Problems: Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_

Anaphylaxis: Yes \_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_ Depression: Yes \_\_\_\_\_\_\_No\_\_\_\_\_\_\_ Leukemia: Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

Anemia: Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_ Diabetes: Yes \_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_ Liver Disease: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

Angina: Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_ Emphysema: Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_ Pain in Jaw Joints: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_

Asperger’s Syndrome: Yes \_\_\_\_No\_\_\_\_ Epilepsy/ Seizures: Yes \_\_\_No\_\_\_\_\_\_ Psychiatric Disease: Yes\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

Asthma: Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_ Excessive Bleeding: Yes \_\_\_No\_\_\_\_\_­ Scarlet Fever: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Autism: Yes \_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_ Fainting/Dizziness: Yes \_\_\_\_No\_\_\_\_\_ Sinus Troubles: Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Behavior Issues: Yes \_\_\_\_\_No\_\_\_\_\_\_\_ Headaches: Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_ Stomach/Intestinal Disease: Yes\_\_\_\_ No\_\_\_\_\_\_\_

Blood Disease: Yes \_\_\_\_\_No\_\_\_\_\_\_\_ Herpes: Yes \_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_ Tonsillitis: Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breathing Issues: Yes \_\_\_\_No\_\_\_\_\_\_\_ Heart Issues: Yes \_\_\_\_\_\_No\_\_\_\_\_\_\_\_ Ulcers: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer: Yes \_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_­\_ Heart Attack/Failure: Yes \_\_\_\_No\_\_\_\_ Cold Sores/Fever Blisters: Yes \_\_\_\_No\_\_\_\_\_\_\_\_

Heart Murmur: Yes \_\_\_\_No\_\_\_\_\_\_\_ Congenital Heart Disorder: Yes \_\_\_\_No\_\_\_\_\_\_\_\_ Hepatitis A, B or C: Yes \_\_\_\_\_No\_\_\_\_\_\_\_\_

Convulsions: Yes \_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_ Drug allergies: Yes\_\_\_ No\_\_\_\_ if yes, explain­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any disease or condition not listed above that we should know about? Yes\_\_\_\_ No\_\_\_\_ If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To the best of my knowledge, the questions above have been accurately answered. It is my responsibility to inform Medina Pediatric Dentistry if there are any medical changes.**

Signature of Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_