

MEDICAL HISTORY FOR CHILDREN AND MINORS

This information is for a confidential record necessary in providing quality dental care.

Please help us by providing the following:

Have you been examined and/or treated by a physician in the last year? \_\_\_ Yes \_\_\_ No

Are you taking any medicines, drugs, or pills/herbal remedies now (prescription or over-the-counter)? If so, please list.

\_\_\_\_\_

Are you allergic to any medications listed? If so, please circle.

Dental Anesthesia      Aspirin      Codeine      Penicillin      Latex

Are you allergic to any other medications? If so, please list. \_\_\_\_\_

Have you been seriously ill or hospitalized? \_\_\_\_\_ Yes      \_\_\_\_\_ No

If so, for what? \_\_\_\_\_

\_\_\_\_\_

Have you ever had hepatitis?	Yes	No
Have you had an HIV (Aids) test with positive results?	Yes	No
Have you ever had a blood transfusion?	Yes	No
Do you have any kidney or liver problems?	Yes	No
Have you ever had kidney dialysis?	Yes	No
Have you ever had Rheumatic fever?	Yes	No
Do you have a heart murmur?	Yes	No
Have you ever had a heart attack?	Yes	No
Do you have high blood pressure?	Yes	No
Have you ever had any heart valves replaced?	Yes	No
Do you have Mitral Valve prolapse?	Yes	No
Any other heart problems?	Yes	No
Do you have any hip, knee or other joint replacements?	Yes	No
If so, when were they placed?	_____	

Please circle any of the following conditions that you have had or have at the present time:

Asthma	Sinus Trouble	Epilepsy	Cancer
Hemophilia	Bleeding Problems	Tuberculosis	Diabetes
Stroke	Chest Pains	Angina Pectoris	Glaucoma
Drug Addiction	Alcohol Addiction	Dizzy Spells	Fainting
Allergies			

Do you have any disease, condition or medical problem not listed above? \_\_\_ Yes \_\_\_ No

If yes, please explain. \_\_\_\_\_

Females only-Are you pregnant? \_\_\_\_\_ Yes      \_\_\_\_\_ No      Due Date: \_\_\_\_\_

**Parent/Guardian signing for Minor**      Date \_\_\_\_\_