Medical History

Has your child had any history of, difficulty with, or diagnosis of any of the following:
[please circle Yes or No]

ADD/ADHD	Y | N	Endocrine Disorders	Y | N	Mononucleosis	Y | N
Allergies	Y | N	Epilepsy	Y | N	Surgeries	Y | N
Anemia	Y | N	Fainting	Y | N	Hospitalizations	Y | N
Autism	Y | N	Growth Problems	Y | N	Prolonged Bleeding	Y | N
Blood Transfusions	Y | N	Heart/Circulatory Disease	Y | N	Rheumatic Fever	Y | N
Cerebral Palsy	Y | N	Hearing Issues	Y | N	Seizures	Y | N
Cancer	Y | N	Hepatitis	Y | N	Sickle Cell	Y | N
Chicken Pox	Y | N	HIV/Aids	Y | N	Thyroid	Y | N
Chronic Sinus	Y | N	Kidney/Bladder Issues	Y | N	Tobacco Use	Y | N
Convulsions	Y | N	Liver Problems	Y | N	Girls Menstruation Begin	Y | N
Diabetes	Y | N	Measles/Mumps	Y | N	Boys Voice Changes	Y | N

Other:____

Physician: ______________________ Phone:________________ Currently in Treatment Y | N

Current Treatment for: ______________________ Current Medications: __________________

Allergies: ____

Dental History

Does your child have or had any of the following?

Dental Discomfort	Y | N
Unpleasant Dental Experience	Y | N
Speech Deficits	Y | N
Trauma to Face	Y | N
Frequent Cold Sores	Y | N
Thumb/Pacifier Habits	Y | N
Habit Still Active	Y | N
Mouth Breathing	Y | N
Snoring	Y | N
Jaw Joint Pain	Y | N
Jaw Joint Clicking	Y | N

Dental Hygiene:

Frequency of Daily Brushing	_____ x
Daily Flossing	Y | N
Fluoride in Water	Y | N
Flouride Supplements	Y | N
Fluoride Mouth Rinses	Y | N

Other Comments:

Dentist:______________________ Phone:______________________ Date of Last Visit:________________

Summary of any Other Issues: ____

May we request release of your child's medical or dental records? Y | N

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

Parent of Guardian's signature:________________________________ Date: ____________________