Child Medical History

Date: ___________________________

Patient:____ **Birthdate:** _____/_____/__________

LAST FIRST MIDDLE

Does your child: (Please circle one)

YES **NO** Have a current physician?

Physican: ____ Phone # __________________________________

YES **NO** Take ANY prescription / non-prescription medication(s) or dietary / herbal supplement(s)?
If yes, please list all, including reason why.

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YES **NO** Have any allergies to ANY medications or food products? If yes, please list.

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YES **NO** Have an allergy to latex products?

YES **NO** Require antibiotics prior to dental treatment due to heart murmur, shunt, prosthetic devices, history of rheumatic fever, etc.?

YES **NO** Have any prosthetics? Example: artificial limbs, prosthetic eye, pins, screws, etc.

Female patients:

YES **NO** Currently taking oral contraceptives?
YES **NO** Pregnant? Is so when is she due? ______/______/________ Name of OB: ______________________________________
YES **NO** Nursing?

Do you consider your child to be: (please check one)

_________ Advanced in the learning process
_________ Progressing normally
_________ Slow in the learning process

Please Circle "YES" or "NO" As It Relates To Your Child's Health

YES	**NO**	Heart Murmur / Heart Problems	**YES**	**NO**	HIV positive / AIDS
YES	**NO**	Shunts	**YES**	**NO**	Hemophilia / Bleeding problems / Anemia
YES	**NO**	Cancer	**YES**	**NO**	Hearing Impairment
YES	**NO**	Diabetes	**YES**	**NO**	Speech Issues
YES	**NO**	Rheumatic Fever	**YES**	**NO**	Hyperactive /ADD / ADHD
YES	**NO**	Liver problem / Hepatitis	**YES**	**NO**	Frequent Headaches
YES	**NO**	Kidney Disease	**YES**	**NO**	Asthma Last Attack_____________
YES	**NO**	Convulsions / Epilepsy / Seizures	**YES**	**NO**	Physical / Mental Impairment
YES	**NO**	Autism	**YES**	**NO**	Dermatologic or Skin Conditions

YES **NO** Learning Disability / Developmental Delay
YES **NO** Any hospital stay / operations Please List:____
YES **NO** Are there any other medical conditions or problems relating to your child? If yes, please list:

____

____
Doctor's Signature Date