MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS. CIRCLE YES OR NO; WRITE IN ANSWERS WHERE APPROPRIATE.

Childs name_____

GENERAL INFORMATION

1. Have there been any changes in your child's general health within the past year..... YES NO
2. Has your child been hospitalized within the past year..... YES NO
3. Date of last physical examination_____
   Physician's name_____
   Phone number_____

Has your child had a history of any of the following?

1. Heart murmur (congenital heart disease)..... YES NO
2. Rheumatic heart disease or fever..... YES NO
3. Other heart conditions..... YES NO
4. Asthma..... YES NO
5. Respiratory disease..... YES NO
6. Abnormal bleeding..... YES NO
7. Any blood disorders..... YES NO
8. Epilepsy or Convulsions..... YES NO
9. Fainting spells or seizures..... YES NO
10. Joint replacement..... YES NO
11. Diabetes..... YES NO
12. Radiation or chemotherapy..... YES NO
13. Liver disease..... YES NO
14. Kidney disease..... YES NO
15. A physical disability..... YES NO
16. A mental disability..... YES NO
17. Attention deficit disorder or hyperactivity..... YES NO

Please explain any yes answers_____

_____

_____

MEDICATIONS

Is your child now taking or has your child ever taken:

1. Cortisone (steroids)..... YES NO
2. Inhaler..... YES NO
3. Chemotherapy..... YES NO

Is your child currently taking any medications..... YES NO

List medications your child is currently taking _____

_____

_____

ALLERGIES

Is your child allergic to or ever had a reaction to:

1. Local anesthetic (novocaine, etc.)..... YES NO
2. Penicillin, Sulfa drugs, or other antibiotics..... YES NO
3. Latex..... YES NO
4. Other allergies..... YES NO

Please explain any yes answers_____

_____

DENTAL HISTORY

Does your child have or has your child ever had:

1. Oral habits (thumb/digit sucking, nail biting, etc.)..... YES NO
2. Orthodontics..... YES NO
3. Frequent toothaches..... YES NO
4. Periodontal (gum) disease..... YES NO
5. Grinding or clenching of his or her teeth..... YES NO
6. In general, how has your child's dental experience been:

GOOD AVERAGE POOR

HOME CARE

1. Does your child brush his/her teeth unassisted..... YES NO
2. Fluoride supplements currently taking (circle)

☐ **Toothpaste** ☐ **Rinses** ☐ **None**

☐ **Tablets/drops daily amount**_____**mg**

Please list any other medical problems or information not previously mentioned_____

_____

_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF THERE ARE ANY CHANGES IN MY CHILD'S HEALTH OR IF HER/HIS MEDICINES CHANGE, I WILL INFORM THE STAFF OR DOCTOR JENSEN AT THE NEXT APPOINTMENT.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

MEDICAL HISTORY UPDATE

DATE	CHANGES	PARENT'S SIGNATURE	STAFF INITIAL	CHANGE
_____	YES NO	_____	_____	_____
_____	YES NO	_____	_____	_____