Patient Medical History Form

Name: _____ Preferred Name: _____

Date of birth: ____/____/_____ Birth sex: ▫ M ▫ F Pronouns:_____

Race/Ethnicity: _____ Height: _____in. Weight: _____lbs

Primary physician: _____ Phone Number: _____

Does your child currently see a specialist?.....▫ YES ▫ NO

If yes, what is their name and phone number:_____

_____

Is this your child's first visit to the dentist?.....▫ YES ▫ NO

If no, was there treatment previously completed on your child's teeth?.....▫ YES ▫ NO

1. Has your child ever been hospitalized or treated in an emergency department?.....▫ YES ▫ NO

If yes, please describe:_____

2. Is your child taking any medication (prescription or over the counter), vitamins or dietary supplements? If yes, please list name, dose, frequency and date started below.....▫ YES ▫ NO

3. Is your child up to date on immunizations against childhood diseases?.....▫ YES ▫ NO

4. Is your child allergic to any medications, i.e. antibiotics, sedatives or other drugs?.....▫ YES ▫ NO

If yes, please describe: _____

5. Is your child allergic to anything else, such as latex, metals, dye or specific foods?.....▫ YES ▫ NO

If yes, please describe: _____

6. Is your child speech/hearing/visually impaired?.....▫ YES ▫ NO

If yes, please describe: _____

7. Behavioral, emotional, communication, or psychiatric problems/treatment? .....▫ YES ▫ NO

8. Abuse (physical, psychological, emotional, or sexual) or neglect ..... ▫ YES ▫ NO

9. (For Females) Is there a chance your child may be pregnant? .....▫ YES ▫ NO ▫ N/A

10. Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions .....▫ YES ▫ NO

11. Frequent exposure to tobacco smoke? .....▫ YES ▫ NO

12. Frequent colds or coughs, or pneumonia? .....▫ YES ▫ NO

▫ ADHD/ADD	▫ Eczema	▫ Methicillin Resistant Staphylococcus Aureus (MRSA)
▫ Anemia	▫ Epilepsy / Seizures	
▫ Anxiety	▫ Excessive Bleeding	▫ Mononucleosis
▫ Arthritis	▫ Excessive Gagging	▫ Mouth Breathing
▫ Asthma	▫ Fainting/ Dizziness	▫ Muscle/Joint/ Bone Problems
▫ Autism	▫ Fine/Gross Motor Deficit	▫ Nutritional Deficiencies
▫ Bladder/Kidney Problems	▫ Frequent Headaches/ Migraines	▫ Obesity
▫ Blood Disorder		▫ Pituitary Problems
▫ Blood Transfusions	▫ GERD (Gastroesophageal/ Acid Reflux)	▫ Rheumatic Fever
▫ Brain Injury		▫ Rheumatic Heart Disease
▫ Bruises Easily	▫ Heart Murmur	▫ Scarlet Fever
▫ Cerebral Palsy	▫ Hemophilia	▫ Scoliosis
▫ Chronic Adenoid/Tonsil Infections	▫ Hepatitis	▫ Sexually Transmitted Disease (STD)
	▫ High Blood Pressure	
▫ Congenital Heart Defect/Disease	▫ Human Immunodeficiency Virus (HIV)/AIDS	▫ Sickle Cell Disease/Trait
		▫ Sinusitis
▫ Cystic Fibrosis	▫ Hypoglycemia	▫ Sleep Apnea
▫ Cytomegalovirus (CMV)	▫ Irregular Heart Beat	▫ Thyroid Problems
▫ Developmental Delay	▫ Jaundice	▫ Tuberculosis (TB)
▫ Diabetes (Type 1 / Type 2)	▫ Liver Problems	

14. If your child has any other conditions not previously listed please explain:

_____

_____

_____

_____

15. Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant .....▫ YES ▫ NO

If yes, please describe: _____

16. Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder...▫ YES ▫ NO

17. Hydrocephaly/shunt placement (ventriculoperitoneal, ventriculoatrial, ventriculovenous)...▫ YES ▫ NO

18. **Has your child ever had COVID-19?** .....▫ YES ▫ NO

If yes, when? _____

Signature:_____ Relationship:_____ Date:_____