river city
pediatric dentistry

Child's Name: _____ Child's Nickname: _____

Date of Birth: _____ Sex:_____ Parents' Names: _____

MEDICAL HEALTH HISTORY

Does your child have or has your child had any of the following? (Please check any that apply)

- ❑ Cancer or tumor
- ❑ Cardiovascular disease (Heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
- ❑ Congenital heart disease (Heart murmur, mitral valve prolapse, heart defect)
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Arthritis
- ❑ Tuberculosis or other lung problems
- ❑ Persistent cough or cough up blood
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Thyroid disease
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Depression or other emotional condition
- ❑ Developmental Delay
- ❑ Cognitive Delay
- ❑ Cerebral Palsy
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Sickle Cell Anemia
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Hearing disability
- ❑ Cleft lip or cleft palate
- ❑ Down Syndrome
- ❑ Autism
- ❑ Was your child premature? If yes, how many weeks?_____
- ❑ Grinding/clenching teeth
- ❑ Snoring
- ❑ Pain/soreness in jaw or TMJ
- ❑ Toothaches
- ❑ Orthodontic treatment (Braces)

Is your child allergic to, or have they reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Foods (Please list):_____
- ❑ Other:_____

Is your child taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Dilantin or other anticonvulsant
- ❑ Cortisone or other steroids
- ❑ Other:_____

Last date of dental examination:_____

Name of your child's physician:_____ Phone number of your child's physician:_____

Does your child have any disease, condition, or problem not listed above? If so, please explain below:

_____

Please add anything else you would like us to know about:_____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Parent: _____ Date: _____

Signature of Dentist: _____ Date: _____