

NAME _____ DOB _____

Medical and Dental Health History
Anne R. Lee, DDS :: Pediatric Dentistry

Your child's health, as well as any medications which your child takes, can have an interrelationship with the dental care your child receives. Please answer each question completely.

Present Health:

- Name of physician: _____ Phone _____ **YES** **NO**
- Is your child presently under care for any medical problems or conditions?..... _____
- Is your child currently taking any drugs or medications?..... _____
- Has your child has a history of any of the following?..... _____
 - Congenital heart disease, heart murmur, heart damage from rheumatic fever..... _____
 - Blood disorders, bleeding problems, anemia or sickle cell disease..... _____
 - Seizure disorders, epilepsy, convulsions, cerebral palsy or brain injury..... _____
 - Sight or hearing disorders or limitations..... _____
 - Asthma, pneumonia, tuberculosis, cystic fibrosis, or breathing difficulties..... _____
 - Stomach intestinal, kidney, or liver problems; including jaundice or hepatitis..... _____
 - Diabetes, thyroid disorders or other glandular problems..... _____
 - Immune system disorders, including HIV/AIDS..... _____
 - Cancer, tumor, or growths..... _____
 - Joint or limb problems, including arthritis, or muscle problems or weaknesses..... _____
 - Allergies to any drugs, medications, or to latex..... _____
- Are there any other medical problems or conditions you feel should be brought to the doctor's attention?..... _____
 - If so, what? _____

Growth and Developmental History:

- Was your child premature or low birthweight?..... _____
- Did nursing, bottle feeding, or bottle habits continue beyond 18 months of age?..... _____
- Does your child have any of the following oral habits?..... _____
 ___ Thumb ___ Finger(s) ___ Pacifier ___ Blanket
- Does your child have any learning disabilities, developmental delay, or intellectual impairment? Please elaborate _____
- Does your child have any behavioral problems, attention disorders, or communication problems? Please elaborate _____
- Has your child received behavioral, psychologic, or psychiatric evaluation or counseling?... _____

Dental History:

- Is this your child's first dental visit? If not, date of last dental visit _____
- Has your child had an unfavorable experience in a previous dental or medical office?..... _____
- Are you aware of any current dental problems which you expect will require treatment?.... _____
- Has your child experienced injuries to the mouth, teeth, or jaws?..... _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and records of treatment or examination rendered to my child during the period of care to third party payors and/or health practitioners. I further acknowledge receipt of the Dental Materials Fact Sheet and HIPAA Privacy Act.

Signature of Parent or Guardian _____ Date _____
Reviewed by Dentist: _____ Date _____