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_____