toothtales™

CHILD MEDICAL HISTORY UPDATE

Name: ..... Date of Birth: ..... Date Form Created: .....

Please answer the following questions for your child as accurate as possible:

1. Does your child have a primary care physician? Y / N If yes, ...
2. Has your child ever been hospitalized or had a major operation? Y / N If yes, ...

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3. Is your child taking any medications? Y / N If yes, ...

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4. Is your child on a special diet? Y / N If yes, ...

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5. Is your child allergic to any of the following? ◯ Penicillin ◯ Aspirin ◯ Latex ◯ Sulfa Drugs
   Other? .....

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6. Please specify if your child has any history or currently has any of the following:

◯ Hemophilia	◯ Mental Delays	◯ Diabetes	◯ Stomach/Intestinal Disease
◯ Physical Delays	◯ Bleeding Disorders	◯ Herpes	◯ High Blood Pressure
◯ Epilepsy or Seizures	◯ High Cholesterol	◯ Anemia	◯ Congenital Heart Disorder
◯ Eating Disorders	◯ Hypoglycemia	◯ Asthma	◯ Sickle Cell Disease/Trait
◯ Blood Disease	◯ Irregular Heartbeat	◯ Sinus Trouble	◯ Fainting Spells/Dizziness
◯ Autism Spectrum	◯ Cerebral Palsy	◯ Anaphylaxis	◯ Breathing Problems
◯ Frequent Headaches	◯ Low Blood Pressure	◯ Bruise Easily	◯ Cancer/Tumors
◯ Thyroid Disease	◯ Chemotherapy	◯ Tuberculosis	◯ Cold Sores/Fever Blisters
◯ Heart Murmur	◯ TMJ Problems	◯ Hives or Rash	◯ Heart Trouble Disease
◯ Psychiatric Care			

7. Has the patient ever had any serious illness not listed above? Y / N If yes, ...

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8. Please write any additional information in this section that would be important for the doctor to know: .....

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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 medical status.

Signature of: ◯ Patient ◯ Parent ◯ Guardian

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Signature Date

OFFICE USE ONLY

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Doctor Signature Date