Pediatric Medical History

Patient Name:_____ **DOB:**_____ **Gender (please circle one): M F They/Them**

Emergency Contact:_____ **Phone:**_____**Relationship:**_____

It is important that I know about your child's dental and medical history. These facts have a direct bearing on their dental health. This information is strictly confidential and will not be released to anyone with out your consent. Thanks our for taking the time to complete this form in its entirety.

Dental History:

Is your child's present dental health good?_____ **Y** **N**
If no, explain:_____
_____
Is this your child's first dental visit?_____ **Y** **N**
Does your child use bottle, pacifier, or suck thumb/finger? _____ **Y** **N**
If yes, specify: _____
Does your chiles show age-appropriate behavior?_____ **Y** **N**
If no, explain:_____
_____
Anything special you would like us to know about your child?_____ **Y** **N**
If yes, explain: _____
_____
Has you child used fluoridated toothpaste and/or vitamins?_____ **Y** **N**
Does you child drink **tap** or **bottled** water or **both**? Circle one
Has you child ever worm braces or clear aligners? (orthodontics)_____ **Y** **N**
Does your child use floss regularly? _____ **Y** **N**
Does your child have any dental problems now?_____ **Y** **N**
If yes, specify:_____
_____

About Your Child

Please list any sports/activities your child enjoys:_____
_____
Hobbies:_____
_____
Favorite TV show, movie, reading material:_____
_____
What does your child like best about school?:_____

Date of last physical exam:_____
List ANY medications and dosage your child is currently taking:_____
_____
_____

Medical History:

Does your child have any of the following (circle Y or N):

AIDS/HIV Positive	**Y**	**N**	Heart Murmur	**Y**	**N**	Tuberculosis	**Y**	**N**
Anaphylaxis	**Y**	**N**	Heart Surgery	**Y**	**N**	Venereal disease	**Y**	**N**
Anemia	**Y**	**N**	**Heart problems***	**Y**	**N**	Ulcerative Colitis	**Y**	**N**
Arthritis(Rheumatism)	**Y**	**N**	Hemophilia	**Y**	**N**			
Artificial Heart Valves	**Y**	**N**	Herpes	**Y**	**N**			
Artificial Joints	**Y**	**N**	Hepatitis	**Y**	**N**			
Asthma	**Y**	**N**	High blood pressure	**Y**	**N**			
Atopy(allergy Prone)	**Y**	**N**	Jaw pain	**Y**	**N**			
Back problems	**Y**	**N**	Kidney disease	**Y**	**N**			
Blood disease	**Y**	**N**	Liver disease	**Y**	**N**			
Cancer	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**			
Chemical Dependency	**Y**	**N**	Nervousness	**Y**	**N**			
Chemotherapy	**Y**	**N**	Pacemaker	**Y**	**N**			
Circulatory problems	**Y**	**N**	Psychiatric Care	**Y**	**N**			
Cortisone treatments	**Y**	**N**	Rapid weight gain/loss	**Y**	**N**			
Cough (persistent)	**Y**	**N**	Radiation treatment	**Y**	**N**			
Cough up blood	**Y**	**N**	Respiratory disease	**Y**	**N**			
Diabete	**Y**	**N**	Rheumatic/Scarlet fever	**Y**	**N**			
Epilepsy	**Y**	**N**	Shortness of breath	**Y**	**N**			
Fainting	**Y**	**N**	Skin rash	**Y**	**N**			
Food Allergies	**Y**	**N**	Stroke	**Y**	**N**			
Glaucoma	**Y**	**N**	Surgical implant	**Y**	**N**			
Headaches	**Y**	**N**	Type:_____					
Hearing difficulties	**Y**	**N**	Thyroid disease	**Y**	**N**			
Heart attack	**Y**	**N**	Tobacco use	**Y**	**N**			

***Please list type of heart problems**:_____
_____

ALLERGIES:

Please list any allergies to **MEDICATION**:_____
_____
_____
_____
Please list any **FOOD** allergies:_____
_____
_____
_____
LATEX ALLERGY **Y** **N**
Other material allergy:_____

I certify that I have read and understand this form. To the best of my knowledge I have answered every question completely and accurately. I will inform my Dentist of any change in my health and/or medication. I will not hold Dr. Gavros, any associate or staff member, responsible for any errors or omissions that I may have made in the completion of the form. Please sign below:

Signature of Patient's Parent or Guardian:_____ **Date:**_____

Signature of Licensed Provider:_____ **Date:**_____

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