For the following medical history questions, please (x) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your child's health. This information is vital to allow us to provide appropriate care for your child.

DENTAMED HEALTHCARE

# Medical History

Does your child have or has ever had any of the following conditions:

| Yes | No | Unsure | | Yes | No | Unsure | | Yes | No | Unsure | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ | Herpes | ☐ | ☐ | ☐ | Radiation Treatment |
| ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | Chronic Ear Infections |
| ☐ | ☐ | ☐ | Autism | ☐ | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | ☐ | Pregnant (at this time) |
| ☐ | ☐ | ☐ | ADHD/ADD | ☐ | ☐ | ☐ | Hyperactivity | | | | |
| ☐ | ☐ | ☐ | Birth Defects | ☐ | ☐ | ☐ | Kidney Disease | ☐ | ☐ | ☐ | Sexually Transmitted Diseases |
| ☐ | ☐ | ☐ | Bleeding Problems | ☐ | ☐ | ☐ | Learning Disabilities | | | | |
| ☐ | ☐ | ☐ | Blood Disorders | ☐ | ☐ | ☐ | Liver Disease | ☐ | ☐ | ☐ | Hearing Loss/Impairment |
| ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | Mental Disability | | | | |
| ☐ | ☐ | ☐ | Cerebral Palsy | ☐ | ☐ | ☐ | Muscular Dystrophy | ☐ | ☐ | ☐ | Heart Conditions/Murmur |
| ☐ | ☐ | ☐ | Developmental Delay | ☐ | ☐ | ☐ | Psychiatric Problems | ☐ | ☐ | If yes to heart murmur, is an antibiotic required before dental appointments? | |
| ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ | Rheumatic Fever | | | | |
| ☐ | ☐ | ☐ | Downs Syndrome | ☐ | ☐ | ☐ | Seizures | | | | |
| ☐ | ☐ | ☐ | Emotional Problems | ☐ | ☐ | ☐ | Sickle Cell Anemia | ☐ | ☐ | ☐ | Jaundice (not at birth) |
| ☐ | ☐ | ☐ | Epilepsy | ☐ | ☐ | ☐ | Skin Disorders | | | | |
| ☐ | ☐ | ☐ | Fainting Spells | ☐ | ☐ | ☐ | Tuberculosis | ☐ | ☐ | ☐ | Delayed Speech Development |
| ☐ | ☐ | ☐ | Hepatitis | ☐ | ☐ | ☐ | Tumors | ☐ | ☐ | ☐ | Allergies: _____ _____ |

| Please explain all "Yes" or "Unsure" responses: |
|---|
| Please list any other problems/conditions your child may have |

## Current Medications List

Is your child taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? ☐ Yes ☐ No If yes, please list medications.

| Medication | Reason for Taking | How Much | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

To the best of my knowledge, the indicated health history remains current.
I understand that any change in the patient's health or medication requires that an updated form be completed.
I certify that I have read and understand the above.
I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.
I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____/_____ Date_____/_____/_____

(Print) parent/guardian (Signature) parent/guardian

**Emergency Contact Information**:

Name: _____ Relationship: _____

Emergency Number: _____

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