

Dental Health History

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Male _____ /Female _____

CHIEF COMPLAINT

Is your child/ward, having any dental problems today? Y _____ N _____

Please List: _____

History of Present Illness (HPI)

Is your child/ward:

- In good health? Y _____ N _____
- Experiencing persistent swollen glands in his/her neck? Y _____ N _____

MEDICAL HISTORY

Is your child/ward:

- Under the care of a physician? Y _____ N _____
Name, Town and Phone # of Physician: _____
- Taking, or have taken in the past, Bisphosphonate Medications (medicine for stronger bones)? Y _____ N _____
- Experiencing bleeding abnormalities? Y _____ N _____
- Being treated for prosthetic (artificial) heart valves or prosthetic (artificial) joints? Y _____ N _____
- Being treated for any condition that requires you to take an antibiotic prior to receiving dental treatment? Y _____ N _____
- Has your child/ward, had any problems associated with any previous dental treatment? Y _____ N _____

Please explain: _____

Are you aware of, or have ever been told by a physician that your child/ward, have any of the following symptoms and/or conditions.

Please indicate (✓) in the appropriate box.

MEDICAL CONDITION	Yes	No	MEDICAL CONDITION	Yes	No
1. Heart Disease			34. Jaundice		
2. Heart Attack			35. Cirrhosis		
3. Angina			36. Hepatitis A		
4. Stroke			37. Hepatitis B		
5. Rheumatic Heart Disease			38. Hepatitis C		
6. Endocarditis			39. Autoimmune Disorder		
7. Heart Murmur			40. Lupus		
8. Pacemaker			41. HIV		
9. Hypertension (High Blood Pressure)			42. AIDS		
10. Hypotension (Low Blood Pressure)			43. STD (Sexually Transmitted Disease)		
11. Chest Pain			44. Chronic Diarrhea		
12. Shortness of Breath			45. Heartburn		
13. Seasonal Allergies			46. Acid Reflux		
14. Sinusitis (Sinus Trouble)			47. Ulcers		
15. Asthma			48. Seizures		
16. Respiratory Disease			49. Epilepsy		
17. Emphysema			50. Syncope (Fainting Spells)		
18. COPD			51. Mental Illness		
19. Cystic Fibrosis			52. Depression		
20. Bronchitis			53. Anxiety		
21. Chronic Cough			54. ADHD		
22. Tuberculosis			55. Down Syndrome		
23. Clotting Disorders			56. Autism		
24. Hemophilia			57. Cerebral Palsy		
25. Sickle Cell Disease/Trait			58. Arthritis		
26. Anemia			59. Rheumatoid Arthritis		
27. Diabetes			60. Osteoporosis		
28. Thyroid Disease			61. Cancer(Tumors or Growths)		
29. Hyperthyroidism			62. Menstrual Irregularity		
30. Hypothyroidism			63. Do you have any other conditions that we should be aware of?		
31. Kidney Disease					
32. Dialysis					
33. Liver Disease					

Please List:

Dental Health History

Patient Name: _____

Date of Birth: _____

CURRENT MEDICATIONS

1. Is your child/ward, currently taking any medications? Y _____ N _____
2. Please list all Prescription and non-prescription medicines (with strength and dosing) your child/ward, is currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES/INTOLERANCE

1. Does your child/ward, have any allergies? Y _____ N _____
2. Does your child/ward, allergic to, had a reaction to, or been told not to take the following medications:
Latex _____ Penicillin _____ Sulfa Rx _____ Codeine _____ Local Anesthetic _____
3. Please list any other allergies:

_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY

1. Has your child/ward, had any serious illness or surgery? Y _____ N _____
2. What was the illness or surgery? _____

3. Has your child/ward, had radiation for a tumor? Y _____ N _____
4. Has your child/ward, had Joint Replacement surgery? Y _____ N _____
Type: _____
5. Has your child/ward, had Heart Valve Replacement surgery? Y _____ N _____

HOSPITALIZATION HISTORY

1. Has your child/ward, been hospitalized? Y _____ N _____
2. For what? _____

Parent or Guardian Signature

Date

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.