Hillside Family Dental Care

Children's Medical History Form

Date: _____

Name: _____ **Preferred Name**: _____ **Date of Birth**: _____

Parent's/Guardian's Name: _____**Relationship to Patient**: _____

Have you (the parent/guardian) or the patient had any of the following diseases or problems?

- Active Tuberculosis?
- Persistent cough greater than 3 weeks duration?
- Cough that produces blood?

If yes to any of the above, please stop and return this form to the front desk.

Physician's Name: _____

Physician's Location: _____ **Physician's Phone**: _____

Is the child currently under a physician's care for an **ongoing health issue**? _____
If yes, please explain: _____

Has the child ever been **hospitalized or had a major operation**? _____
If yes, please explain: _____

Has the child ever had a serious **head or neck injury**? _____
If yes, please explain: _____

Is the child taking any **medications**? _____
If yes, please list:
_____

Is the child **allergic to any medications or foods**? _____

Does the child have, or have they had, any of the following **medical conditions**? Please answer **yes or no to all**.

ADD/ADHD	Y ☐ N ☐	Congenital Heart Disorder	Y ☐ N ☐	Leukemia	Y ☐ N ☐
AIDS/HIV Positive	Y ☐ N ☐	Diabetes	Y ☐ N ☐	Liver Disease	Y ☐ N ☐
Anemia	Y ☐ N ☐	Epilepsy	Y ☐ N ☐	Rheumatic Fever	Y ☐ N ☐
Anxiety	Y ☐ N ☐	Fainting Spells/Dizziness	Y ☐ N ☐	Sickle Cell Disease	Y ☐ N ☐
Arthritis/Rheumatoid	Y ☐ N ☐	Heart Disease	Y ☐ N ☐	Sinus Trouble	Y ☐ N ☐
Asthma	Y ☐ N ☐	Hepatitis	Y ☐ N ☐	Sleep Apnea	Y ☐ N ☐
Autism Spectrum	Y ☐ N ☐	Herpes	Y ☐ N ☐	Thyroid Disease	Y ☐ N ☐
Bleeding Disorders	Y ☐ N ☐	Hives/Rash	Y ☐ N ☐	Tuberculosis	Y ☐ N ☐
Bone/Joint Problems	Y ☐ N ☐	Intestinal Disease	Y ☐ N ☐	Tumors/Growths	Y ☐ N ☐
Cancer	Y ☐ N ☐	Kidney Problems	Y ☐ N ☐		

If the child has **any other serious illness not listed** or said **yes to any of the above**, please explain:
_____
_____

Over →

Name: _____ **Date**: _____ **Date of Birth**: _____

Is this the child's **first visit** to a dentist? _____

What type of **water does your child drink**, i.e. city water, well water, or bottled? _____

Does the child use **fluoride toothpaste**? _____

How many times are the child's **teeth brushed per day**?
When: Morning _____ Lunch _____ Bedtime _____

What is the **reason for your visit today**? _____

AUTHORIZATION AND RELEASE:
To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to the child's health. It is my responsibility to inform the dental staff of any changes in the child's medical status.

Signature of parent or guardian: _____Date: _____

Reviewed by: _____Date: _____