

# MEDICAL HISTORY

Patient: Submitted: 11/7/2025

Patient Name / DOB /  
Today's Date

## Disclaimer

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

## Health History

### General Health Questions

Is your child currently seeing a physician/  
pediatrician? Yes [ ] No [ ]

History of Hospitalizations or Emergency Room  
Care? (If yes, why and when?) Yes [ ] No [ ]

Is your child currently taking any medications? (If  
yes, please list them) Yes [ ] No [ ]

Is your child allergic to any of the  
following?

Penicillin: [ ]	Codeine: [ ]	Latex: [ ]	<b>Allergies</b>
Seasonal: [ ]	None: [ ]	Other, if other please list: [ ]	

### Has your child had history or difficulty with any of the following:

No conditions

Blood Disorder/Anemia Yes [ ] No [ ] Liver Disease/Jaundice/  
Hepatitis Yes [ ] No [ ]

Psychiatric/Emotional  
Disorder Yes [ ] No [ ] Immune Disorder/HIV/  
AIDS Yes [ ] No [ ]

Stomach/GI Disease Yes [ ] No [ ] Congenital Birth Defects Yes [ ] No [ ]

Cancer/Tumors (If yes,  
please explain) Yes [ ] No [ ] Asthma/Reactive Airway Yes [ ] No [ ]

Social Delay Yes [ ] No [ ] Endocrine Disorders/  
Diabetes (If yes, what  
type?) Yes [ ] No [ ]

Rheumatic Fever Yes [ ] No [ ] Behavioral Problems Yes [ ] No [ ]

Seizure/Epilepsy Yes [ ] No [ ] Cleft Lip & Palate Yes [ ] No [ ]

Speech Disorder Yes [ ] No [ ] Heart Disease/Murmur Yes [ ] No [ ]

Premature/Low Birth  
Weight Yes [ ] No [ ] Eating Disorder Yes [ ] No [ ]

High/Low Blood Pressure Yes [ ] No [ ] Cerebral Palsy Yes [ ] No [ ]

Hearing Loss Yes [ ] No [ ] Bone Joint Problems Yes [ ] No [ ]

Kidney Disease Yes [ ] No [ ] ADD/ADHD Yes [ ] No [ ]

Autism Spectrum Yes [ ] No [ ] Vision Problems Yes [ ] No [ ]

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Spinal Bifida Yes [ ] No [ ] Head/Neck Injury Yes [ ] No [ ]  
Injuries to Face/Mouth Yes [ ] No [ ] Lung/Breathing Problem Yes [ ] No [ ]  
Other Condition(s) Not Listed (If yes, please specify) Yes [ ] No [ ]

## Dental History

### General Dental Questions

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Has your child ever been to the dentist? If yes, please state the last time they were seen Yes [ ] No [ ]

Do you or your child have any concerns about their teeth or oral health? If yes, please explain Yes [ ] No [ ]

What is the reason for today's visit?

Cleaning: [ ]	Treatment (fillings, crowns, extractions, etc): [ ]	Other: [ ]
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Does your child brush their teeth? If yes, how many times per day? Yes [ ] No [ ]

Does your child use dental floss? If yes, how many times per day? Yes [ ] No [ ]

Does your child use fluoride toothpaste? Yes [ ] No [ ]

Does your child use a fluoride rinse? Yes [ ] No [ ]

Does your child use a fluoride supplement(s)? Yes [ ] No [ ]

Does your child snack between meals? Yes [ ] No [ ]

Do you think your child reacts well to dental treatment? Yes [ ] No [ ]

### Does your child have any of the following oral habits?

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Thumb/Finger Sucking	Yes [ ] No [ ]	Lower Lip Sucking	Yes [ ] No [ ]
Tongue Thrust	Yes [ ] No [ ]	Mouth Breathing	Yes [ ] No [ ]
Pacifier	Yes [ ] No [ ]	Bottle Feeding	Yes [ ] No [ ]

## Sign Form

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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.