CHILD MEDICAL HISTORY

Date: ______________

Name: ____ Date of Birth: ___________ Age: ______
Last First Middle

Address: ____
Number & Street City State Zip

Phone: ____________________________ Email: ____

In the following sections, please circle yes or no (whichever applies). Your answers are for our records and will be kept confidential.

Medical Information:

1) Overall, do you consider your child to be in good general health? .... YES NO

2) Have there been changes in your child's health in the past year? .... YES NO
If yes, explain:

3) Is your child currently under the care of a physician? .... YES NO
Physician Name(s):

Physician Contact Information:

4) Has your child been hospitalized or had any serious illness or operation? .... YES NO
If yes, explain:

5) Does your child have/had any of the following medical conditions?

- Cardiovascular Disease (heart trouble, high blood pressure, heart attack, arteriosclerosis, etc.) .... YES NO
- Congenital Heart Conditions .... YES NO
- Rheumatic Fever or Rheumatic Heart Disease .... YES NO
- Diabetes .... YES NO
- Cancer .... YES NO
- Chemotherapy or Radiation .... YES NO
- Fainting Spells or Seizures .... YES NO
- Bleeding Concerns .... YES NO
- Blood Disorders (i.e. anemia, etc.) .... YES NO
- Asthma .... YES NO
- Kidney Disease .... YES NO
- Liver Disease .... YES NO
- Hepatitis .... YES NO
- HIV Positive / AIDS .... YES NO
- Tuberculosis (TB) .... YES NO
- Sinus Issues .... YES NO
- Jaw Joint Clicking or Pain (TMJ) .... YES NO
- Emotional or Psychiatric Problems .... YES NO
- History of Alcohol or Drug Abuse/Addiction .... YES NO

6) Does your child have a condition or problem not listed above? .... YES NO
If yes, explain:

7) Has your child experienced abnormal bleeding with surgery, extractions, or trauma? ……………………………........................... YES NO

8) Do your child have any artificial heart valves or joints?................................ YES NO

9) Has your child had to take antibiotics prior to past dental visits for any other reason? ……………………………........................... YES NO

10) Has you child had radiation treatment or surgery for a tumor, growth, cancer, or any other condition of head or neck? ……………………………………………………. YES NO

11) Is your child now taking/have taken any of the following medications?

- Antibiotics …………...………………………………. YES NO
- Anticoagulants (blood thinners), including Aspirin……………… YES NO
- Steroid Medication (i.e. prednisone, cortisone, etc.) ………………… YES NO
- Insulin ………………………………..………… YES NO

Medications:

Please list all medications that your child is currently taking (Prescription and Over The Counter):

Allergies:

Please list all known allergies for your child. Please outline allergy and associated response.

I understand that, to the best of my knowledge, all of the preceding answers are true, accurate, and correct. If my child ever has any change in his/her health or medications, I will inform their health care provider immediately. I hereby give my consent to treatment for my child, or the named patient (of whom I am the parent, legal guardian, or foster parent) to Advanced Dental Services of Jacksonville.

Name (Print) Signature Date