CANTRELL FAMILY DENTISTRY

CHILD'S MEDICAL HISTORY

Child's Name_____ Preferred Name_____

Birthdate _____ ☐ Male ☐ Female Birthplace _____

Month - Day - Year

Parent(s)/Guardian(s) Name _____

DENTAL INFORMATION:

Previous Dentist (If Applicable)_____ City/State_____

1. Is there a particular situation you would like examined today? Yes No If "yes", explain: _____

_____

2. When was your child's last dental checkup and cleaning? _____
3. Has your child been seeing a dentist for regular checkups and care? Yes No
4. Has your child had any negative experiences with dentists or doctors? Yes No What, If any: _____

_____

MEDICAL INFORMATION:

Child's physician_____ Phone No._____

Address _____

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

	YES	NO
A) Heart disease, murmur or rheumatic fever? (PLEASE CIRCLE ONE)	☐	☐
B) High or low blood pressure (PLEASE CIRCLE ONE)	☐	☐
C) Hay fever, sinus problems, or allergies	☐	☐
D) Cold sores, fever blisters	☐	☐
E) Diabetes (Type 1 or Type 2) (PLEASE CIRCLE ONE)	☐	☐
F) Low birth weight / premature	☐	☐
G) Autism / Autism Spectrum Disorder	☐	☐
H) Cerebral Palsy	☐	☐
I) Kidney disease	☐	☐
J) Cancer, tumors, other growths	☐	☐
K) Radiation or chemotherapy	☐	☐
L) Reactions or allergies to any of the following:	☐	☐
☐ Aspirin or other pain medication		
☐ Foods ☐ Latex ☐ Antibiotics		
☐ Dental anesthetics ☐ Other (food dye, etc.)		
If yes to any of above, specify _____		
M) Immunologic deficiency disease (Leukemia, AIDS/HIV positive, other)	☐	☐
N) Liver disease (Hepatitis, jaundice)	☐	☐

	YES	NO
O) Thyroid problems	☐	☐
P) Lung disease (TB, asthma, persistent cough, other) (PLEASE CIRCLE ONE) Date of last asthma attack_____ If child has an inhaler, bring to all appointments.	☐	☐
Q) Epilepsy, seizures, fainting spells	☐	☐
R) Arthritis	☐	☐
S) Sore throats, tonsillitis, earaches	☐	☐
T) Venereal disease	☐	☐
U) Abnormal bleeding or blood disorders If yes, what _____	☐	☐
V) Smoke or use other forms of tobacco	☐	☐
W) ADD or ADHD	☐	☐
X) Behavior and/or emotional problems	☐	☐
Y) Take any drugs or medications If yes, what _____	☐	☐
Z) Does your child receive regular vaccinations / immunizations	☐	☐
AA) Is your child adopted?	☐	☐
IF YES Does he/she know?	☐	☐
BB) Has your child been treated or currently being treated for any chemical dependency?	☐	☐

Any other conditions/syndromes (Example: Down syndrome, cleft lip/palate, developmental delays) we should be aware of? _____

_____

FEMALES

Is there any possibility your child could be pregnant? ... ☐ ☐ Does she take birth control medication? ..... ☐ ☐

_____

Signature of Parent/Legal Guardian_____ ***Date:***_____