Pediatric Health History

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dental studio

Patient Information

* First Name _____ Middle Initial _____ Last Name _____

Medical History

* Patient's Primary Care Physician

Physician's Name _____ Physician's Phone Number _____

Physician's Address (Street or PO Box, City, State, Zip Code)

_____

* What is the date (or approximate date) of patient's last medical exam? _____

* Has the patient ever had complication following dental treatment or had negative dental experiences?
yes ☐ no ☐ If yes, please explain.

Behavioral / Developmental

* Has the patient ever been diagnosed as having behavioral issues, ADD, ADHD, Autism Spectrum, or Developmental Delay? yes ☐ no ☐
If you answered yes, please provide additional details. What works best for us to help your child through their visit?

Lungs

* Has the patient ever had or been treated for Asthma or any other breathing problems? yes ☐ no ☐
If you answered yes, please specify which condition the patient has and provide any other additional details:

Other Health

* Are their any other conditions the patient has that we should be aware of? yes ☐ no ☐
If you answered yes, please specify which condition the patient has and provide any other additional details:

* Please list all medications the patient is currently taking (including over-the-counter and herbal products). Also include dosage, frequency, and the reason the patient is taking the medication.

* Please list any allergies and/or bad reactions the patient has had. Include what the patient reacted to, what happened to the patient, and how severe it was.

* Please list all operations and/or hospitalizations the patient has had and approximate dates.

Acknowledgment

To the best of my knowledge, all of the proceeding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

Relationship of person completing this form to the patient. _____

Signature

Date