Child's Physician _____

Address of Physician _____

Physician's Phone Number _____

Date of last physical _____

Is child under the care of a physician now? Yes__ No__ If yes, for what reason? _____

_____

Is child receiving any medications or drugs? Yes__ No__ If yes, please explain

_____

Is there any excessive bleeding when cut? Yes__ No__
Is there a history of heart problems? Yes__ No__ If yes, please explain _____

_____

Has the child had rheumatic fever? Yes__ No__
Has the child ever been hospitalized? Yes__ No__ If yes, please explain _____

_____

Has the child ever had surgery? Yes__ No__ If yes, please explain _____

_____

Is there any ALLERGY to penicillin or other drugs? Yes__ No__ If yes, please explain _____

Any other allergies: Food, pollen, animals, etc.? Yes__ No__ If yes, please explain _____

Does child have poor physical coordination? Yes__ No__ If yes, please explain _____

Are there any emotional problems? Yes__ No__ If yes, please explain _____

Family history of juvenile diabetes, hodgkins, leukemia? Yes__ No__ If yes, please explain _____

Has the child had the following immunizations Please check
( ) Tetanus ( ) Diphtheria ( ) Pertussis ( ) Measles Vaccine ( ) Polio Vaccine

Has your child any history of, or difficulty with, any of the following? Please check ( ) AIDS ( ) Anemia ( ) Asthma ( ) Bladder
( ) Cancer ( ) Convulsions ( ) Cerebral Palsy ( ) Diabetes ( ) Epilepsy ( ) Fainting ( ) Hearing ( ) Chicken Pox ( ) Hemophilia
( ) Hepatitis ( ) Heart ( ) Kidney ( ) Liver ( ) Mononucleosis ( ) Mumps ( ) Rheumatic Fever ( ) Thyroid ( ) Tuberculosis

Please explain any of the above items that are checked _____

_____

( ) There is NO history of any of these problems.
Is there anything else we should be aware of regarding your child's health? _____

What is the reason for seeking dental care?

( ) Routine Checkup ( ) New Examination ( ) Toothache ( ) Accident to teeth ( ) Appearance of teeth ( ) Other _____

_____

How do you think your child will react to dental treatment?
( ) Excellent ( ) Good ( )Poor ( ) I don't know
Comment _____

MEDICAL DENTAL HISTORY