Time 4:38 PM Cecil B. Bray, DMD Sally Young, DMD Date 11/29/2017

Medical History for Infants and Children (rev. November 2017)

Patient Name: Birth Date: Date Created:

What name does your child prefer to be called?

Gender:

- [ ] male
- [ ] female

Health problems and medications could have an important interrelationship with a patient's dental care. Please answer all of the following:

Does the child have, or has he/she ever had, or been treated for any of the following?

ADD/ADHD	Yes No	Anemia	Yes No	Arthritis	Yes No
Asthma	Yes No	Autism	Yes No	Bulimia/Anorexia	Yes No
Cancer/Leukemia	Yes No	Chemotherapy	Yes No	Cold Sores/Fever Blisters	Yes No
Developmental Delay	Yes No	Diabetes	Yes No	Ear Problems	Yes No
Eye Problems	Yes No	Epilepsy/Seizures	Yes No	Excessive Bleeding	Yes No
Fainting/Dizziness	Yes No	GERD (acid reflux)	Yes No	Heart Murmur	Yes No
Hepatitis	Yes No	High Blood Pressure	Yes No	Kidney Problems	Yes No
Liver Problems	Yes No	Mouth Ulcers	Yes No	Radiation of Head/Neck	Yes No
Sickle Cell Disease/Trait	Yes No	Speech Problems	Yes No	Spina Bifida	Yes No
Stomach Problems	Yes No	Stroke	Yes No	Sinus Problems	Yes No
Tuberculosis	Yes No	Tumors/Growths	Yes No	Serious Head/Neck Injury	Yes No

Does the child have any other medical problems? Yes No If yes

Does the child see a physician/doctor/health department? Name/Address/Phone Yes No If yes

Is the child taking any medications, pills, or drugs, including over-the-counter drugs? Yes No If yes

Has the child ever been hospitalized? Please explain. Yes No If yes

Does the child have any medical condition for which his/her physician requires antibiotic premedication? Yes No If yes

Is the child allergic to any medications, foods, or substances: If yes, please check or list.

- [ ] Penicillin
- [ ] Latex
- [ ] Bananas
- [ ] Red Dye #40
- [ ] Peanuts
- [ ] Tree Nuts

Other allergies? Yes No If yes

Has the child been to a dentist before? Who?/When? Yes No If yes

Has the child been seen by the Dental Van? When? Yes No If yes

The following questions will help us get to know your child so we can help him/her feel comfortable in our office.

Father's Name

Mother's Name

Does the child live with:

- [ ] Both parents
- [ ] Mother
- [ ] Father
- [ ] Grandparents
- [ ] Foster Care
- [ ] Other

If Other, please explain. [ ] If yes

Does the child attend school or daycare? Where? Yes No If yes

Does the child have brothers or sisters in the home? Yes No If yes

Does the child have pets? Yes No If yes

What activities does the child enjoy? Comment

Is there anything else about your child you believe is important for the dentist to know? Yes No If yes

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 the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____