Confidential Medical & Dental History for a Minor Patient

Today's Date: _____

Patient Name (first, MI, last)**:** _____ Date of birth: _____

Medical History *(Please circle Yes or No for each)*

1. Physician's name: _____ Physician's phone: _____

2. Date of last medical examination? _____ Weight: _____

3. Patient is in good health? Yes / No **If no, why?** _____

4. Patient has regular medical exams? Yes / No

5. Patient is under the care of a physician at this time? Yes / No **If yes, why?** _____

6. Patient is up to date with immunizations? Yes / No

7. Patient is presently taking medications? Yes / No **If yes, what and why?** _____

8. Patient has allergies (medications, food, latex/rubber)**?** Yes / No **If yes, what?** _____

9. Patient has been hospitalized? Yes / No **If yes, why and when?** _____

10. Patient has had any operations? Yes / No **If yes, why and when?** _____

11. Patient has had general anesthesia? Yes / No

12. If yes, were there any complications? Yes / No **If yes, please explain complications:** _____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Anemia	Yes / No	Heart defects
Yes / No	Arthritis, rheumatism	Yes / No	Heart disease /defects / murmurs
Yes / No	Artificial prosthesis, organs, joints, implants, shunts, valves	Yes / No	Hepatitis
Yes / No	Asthma	Yes / No	High blood pressure
Yes / No	Blood disorder	Yes / No	Jaundice
Yes / No	Blurred vision	Yes / No	Joint pain or stiffness
Yes / No	Bone pain	Yes / No	Kidney or bladder disease
Yes / No	Canker or cold sores	Yes / No	Muscle pain, weakness
Yes / No	Chest pain, tightness, wheezing	Yes / No	Persistent cough or runny nose
Yes / No	Diabetes	Yes / No	Recent significant weight loss
Yes / No	Diarrhea or constipation	Yes / No	Rheumatic fever
Yes / No	Ear infections	Yes / No	Seizures
Yes / No	Eating disorders	Yes / No	Sexual transmitted disease
Yes / No	Excessive thirst	Yes / No	Shortness of breath
Yes / No	Eye disease	Yes / No	Skin disease
Yes / No	Fainting spells	Yes / No	Spina bifida
Yes / No	Family history of diabetes	Yes / No	Stomach problems or ulcers
Yes / No	Fever	Yes / No	Stroke
Yes / No	Frequent urination	Yes / No	Thyroid disease
Yes / No	Frequent vomiting	Yes / No	Transplants
Yes / No	Headaches	Yes / No	Tuberculosis
Yes / No	Hearing problems, ear pain	Yes / No	Tumors or cancer
Yes / No	Heart attack	Yes / No	Urinary tract Infections

This information will not be released unless specifically authorized by patient.

Yes / No	Treatment for emotional, mental, or physical delays	Yes / No	Anxiety
Yes / No	AIDS/HIV	Yes / No	Depression

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No

14. If yes, explain: _____

15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

(dental history continued on next page)

Dental Health History

16. Is this the patient's first dental visit? Yes / No **Please list the reason for the visit:** _____

17. Date of last dental examination: _____

18. Name of patient's previous dentist: _____

19. Reason(s) for leaving the patient's previous dentist: _____

20. Date of last dental radiographs (X-rays): _____

21. Does the patient respond well to his/her pediatrician or past dentist: Yes / No **If no, please explain:** _____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Injuries to the face, mouth, or teeth	Yes / No	Habits (cheek biting, lip biting/sucking, tongue thrusting)?
Yes / No	Thumb, finger, or pacifier sucking? Until what age:	Yes / No	Speech Problems?
Yes / No	Missing or extra permanent teeth?	Yes / No	Habit of going to bed with a bottle?
Yes / No	Mouth breathing, snoring, enlarged adenoids or tonsils?	Yes / No	Jaw pain, clenching or grinding of teeth?

22. Do you live in a community with fluoridated water? Yes / No ☐ Do not know

23. Does the patient drink tap water? Yes / No

24. Does the patient use any fluoride supplements (rinses, vitamins)? Yes / No **If yes, name of product:** _____

25. How often does the patient brush his/her teeth? _____

26. Does the patient floss his/her teeth? Yes / No **If yes, how often?** _____

27. Has the patient ever been evaluated for or had orthodontic treatment? Yes / No

28. If considering orthodontic treatment, what would you most like it to accomplish for the patient? _____

Authorizations

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact the patient's physician:

Responsible Party's Signature: _____ Date: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my child's dentist of any change in my child's health and/or medication. Further, I will not hold my child's dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Responsible Party Signature (Parent or Guardian): _____ Date: _____

Signature of Dentist: _____ Date: _____

I have reviewed my child's Health History and confirm that it accurately states past and present conditions.

Parent/Guardian Signature: _____ Date: _____

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials