Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name (Medical Doctor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

**Please circle the appropriate answer**

1. Does your child have health problems? YES NO 10. Does he/she bruise easily? YES NO

2. Was your child a patient in a hospital? YES NO 11. Has he/she ever required a blood transfusion? YES NO

3. Date of Last physical exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12. Does he/she have any blood disorders such

4. Is your child now under medical care? YES NO as anemia, etc? YES NO

5. Is your child taking any medication now? YES NO 13. Has he/she ever had surgery, x-ray or chemo-

 If so, for what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ therapy for a tumor, growth, or other condition? YES NO

6. Has your child ever had a serious illness or 14. Does your child have a disability that prevents

 operation? Is so, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO treatment in a dental office? YES NO

7. Does your child have (or ever had) any of the following? 15. Is he/she taking any of the following?

 -Rheumatic fever or Rheumatic heart disease YES NO -Antibiotics or sulfa drugs YES NO

 -Congenital Heart Disease YES NO -Anticoagulants (blood thinners) YES NO

 -Cardiovascular disease (heart trouble, heart -Medicine for high blood pressure YES NO

 attack, coronary insufficiency, coronary occlusion, -Cortisone or steroids YES NO

 high blood pressure, arteriosclerosis, stroke) YES NO -Tranquilizers YES NO

 -Allergies: Food\_\_\_ Medicine\_\_\_\_ Other\_\_\_\_ YES NO -Aspirin YES NO

 -Asthma\_\_\_\_\_ (or) Hay fever\_\_\_\_\_ YES NO -Dilatin or other anticonvulsant YES NO

 -ADHD YES NO

 -Hives or a skin rash YES NO -Insulin, tolbutamide, Orinase YES NO

 -Fainting spell or seizures YES NO -Any Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

 -Hepatitis, jaundice or liver disease YES NO 16. Is he/she allergic to, or reacted adversely to

 -Diabetes YES NO any of the following:

 -Inflammatory rheumatism(painful/swollen joints) YES NO -Local Anesthetics YES NO

 -Arthritis YES NO -Penicillin or other antibiotics YES NO

 -Stomach ulcers YES NO -Sulfa Drugs YES NO

 -Kidney trouble YES NO -Barbituates, sedatives, or sleeping pills YES NO

 -Tuberculosis (TB) YES NO -Aspirin YES NO

 -Persistent cough or cough up blood YES NO -Latex YES NO

 -Venereal disease YES NO 17. Has he/she had any serious trouble associated

 -Epilepsy YES NO with any previous dental treatment? YES NO

 -Sickle cell disease YES NO If so, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 -Thyroid disease YES NO 18. Has your child been in any situation which could

 -AIDS YES NO expose him/her to x-rays or other ionizing

 -Emphysema YES NO radiators? YES NO

 -Psychiatric treatment YES NO 19. Last date of dental exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 -Cleft Lip / Palate YES NO 20. Has he/she ever had orthodontic treatment? YES NO

 -Cerebral Palsy YES NO 21. Has he/she ever been treated for any gum

 -Mental Retardation YES NO disease (gingivitis, periodontitis, trenchmouth)? YES NO

 -Hearing Disabilitiy YES NO 22. Do his/her gums bleed when brushing? YES NO

 -Developmental Disability YES NO 23. Does he/she grind or clench teerh? YES NO

 If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 24. Has he/she often had toothaches? YES NO

 -Was your child premature? YES NO 25. Has he/she had frequent sore in his/her mouth? YES NO

 If yes, how many weeks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 26. Has he/she had any injuries to his/her mouth

 -Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or jaws? Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

8. Does your child have to urinate (pass water) more 27. Does he/she have any sore or swellings of his/her

 than six (6) times a day? YES NO mouth? YES NO

9. Latex Allergy? YES NO

 28. Is your child thirsty much of the time? YES NO

 29. Has your child had abnormal bleeding associated

 with previous surgery, extractions or accidents? YES NO

 Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_