eagle creek children's dentistry

Medical History

Patients Name:_____

ORGANS AND SYSTEMS

HAS THIS CHILD EVER HAD ANY TREATMENT FOR ANY OF THE FOLLOWING? Please check YES or NO:

YES	NO		YES	NO		YES	NO	
☐	☐	BLOOD-CIRCULATORY	☐	☐	GASTROINTESTINAL-STOMACH	☐	☐	NERVOUS SYSTEM
☐	☐	BONES	☐	☐	KIDNEY-BLADDER	☐	☐	SKIN
☐	☐	ENDOCRINE GLANDS	☐	☐	HEART	☐	☐	TONSILS/ADENOIDS
☐	☐	EYES, EARS, NOSE, THROAT	☐	☐	LIVER			
☐	☐	RESPIRATORY-LUNGS	☐	☐	MUSCLES			

ILLNESS

HAS THIS CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?
Please check YES or NO:

YES	NO		YES	NO		YES	NO	
☐	☐	ADHD	☐	☐	EPILEPSY	☐	☐	PSYCHIATRIC DISORDER
☐	☐	AIDS	☐	☐	EXCESSIVE BLEEDING	☐	☐	RHEUMATIC FEVER
☐	☐	ANEMIA	☐	☐	FAINTING	☐	☐	SCARLET FEVER
☐	☐	ALLERGY	☐	☐	HEMOPHILIA	☐	☐	SCOLIOSIS
☐	☐	ARTHRITIS	☐	☐	HEPATITIS-TYPE_____	☐	☐	SICKLE CELL ANEMIA
☐	☐	ASTHMA	☐	☐	JAUNDICE	☐	☐	SINUS PROBLEMS
☐	☐	AUTISM	☐	☐	LEUKEMIA	☐	☐	SNORING AT NIGHT
☐	☐	BRAIN INJURY	☐	☐	MEASLES	☐	☐	SPINA BIFIDA
☐	☐	BRONCHITIS	☐	☐	MENTAL RETARDATION	☐	☐	SYNDROME_____
☐	☐	CANCER	☐	☐	MUMPS	☐	☐	TETANUS
☐	☐	CEREBRAL PALSY	☐	☐	MOUTH BREATHING	☐	☐	TUBERCULOSIS
☐	☐	CHICKEN POX	☐	☐	NUTRITIONAL DEFICIENCY	☐	☐	VENEREAL DISEASE
☐	☐	CLEFT LIP/PALATE	☐	☐	ORAL CONTRACEPTIVES	☐	☐	WHOOPING COUGH
☐	☐	CONVULSIONS/SEIZURES	☐	☐	ORTHOPEDIC PROBLEMS	☐	☐	OTHER_____
☐	☐	DIABETES	☐	☐	PREGNANCY			_____
☐	☐	DIPHTHERIA	☐	☐	PNEUMONIA			_____
☐	☐	DRUG OR ALCOHOL ABUSE	☐	☐	POLIO			

IS THIS CHILD ALLERGIC TO ANYTHING? (MEDICINE, FOOD, ETC.)
If yes, what? _____

IS THIS CHILD ON ANY MEDICATION? YES☐ NO☐

CONDITION: _____

MEDICATION: _____

DOSAGE: _____

Signature:_____ Date:_____

Doctors Signature:_____

ORGANS AND SYSTEMS

HAS THIS CHILD EVER HAD ANY TREATMENT FOR ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO:

YES	NO		YES	NO		YES	NO	
☐	☐	BLOOD - CIRCULATORY	☐	☐	GASTROINTESTINAL - STOMACH	☐	☐	MUSCLES
☐	☐	BONES	☐	☐	KIDNEY - BLADDER	☐	☐	NERVOUS SYSTEM
☐	☐	ENDOCRINE GLANDS	☐	☐	HEART	☐	☐	SKIN
☐	☐	EYES, EARS, NOSE, THROAT	☐	☐	LIVER	☐	☐	TONSILS/ADENOIDS
☐	☐	RESPIRATORY - LUNGS						

ILLNESS

HAS THIS CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS (IMMUNOSUPPRESSIVE DISORDER)	☐	☐	EXCESSIVE BLEEDING PROBLEM	☐	☐	PSYCHIATRIC DISORDER
☐	☐	ANEMIA	☐	☐	FAINTING	☐	☐	RHEUMATIC FEVER
☐	☐	ALLERGY	☐	☐	HEARING LOSS	☐	☐	SCARLET FEVER
☐	☐	ARTHRITIS	☐	☐	HEART DISEASE	☐	☐	SCOLIOSIS
☐	☐	ASTHMA	☐	☐	HEMOPHILIA	☐	☐	SICKLE CELL ANEMIA
☐	☐	AUTISM	☐	☐	HEPATITIS - TYPE _____	☐	☐	SINUS PROBLEMS
☐	☐	BRAIN INJURY	☐	☐	JAUNDICE	☐	☐	SNORING AT NIGHT
☐	☐	BRONCHITIS	☐	☐	LEUKEMIA	☐	☐	SORE THROATS (FREQUENT)
☐	☐	CANCER	☐	☐	MEASLES	☐	☐	SPINA BIFIDA
☐	☐	CEREBRAL PALSY	☐	☐	MENTAL RETARDATION	☐	☐	SYNDROME _____
☐	☐	CHICKEN POX	☐	☐	MUMPS	☐	☐	TETANUS
☐	☐	CLEFT LIP/PALATE	☐	☐	MOUTH BREATHING	☐	☐	TUBERCULOSIS
☐	☐	CONVULSIONS/SEIZURES	☐	☐	NUTRITIONAL DEFICIENCY	☐	☐	VENEREAL DISEASE
☐	☐	DIABETES	☐	☐	ORAL CONTRACEPTIVES/NORPLANT	☐	☐	WHOOPING COUGH
☐	☐	DIPHTHERIA	☐	☐	ORTHOPEDIC PROBLEMS	☐	☐	OTHER _____
☐	☐	DRUG OR ALCOHOL ABUSE	☐	☐	PNEUMONIA			_____
☐	☐	EPILEPSY	☐	☐	POLIO			_____
☐	☐	EYE PROBLEMS	☐	☐	PREGNANT			

☐ **THIS CHILD HAS NEVER BEEN DIAGNOSED AS HAVING ANY OF THE ABOVE CONDITIONS**

IS THERE ANYTHING ELSE THAT YOU THINK WE SHOULD KNOW ABOUT YOUR CHILD? _____

PERMISSION FOR TREATMENT

SIGNATURE OF PERSON COMPLETING FORM _____ *RELATIONSHIP TO PATIENT* _____ *DATE* _____

DO NOT WRITE BELOW THIS LINE

MEDICAL HISTORY SUMMARY

SUMMARIZE FROM PARENT INTERVIEWS OR MEDICAL RECORD. INCLUDE PRECAUTIONARY MEASURES FOR DENTAL CARE. _____

_____

PROPHYLACTIC ANTIBIOTIC RECOMMENDATIONS _____

DENTAL HISTORY SUMMARY

SUMMARIZE BRIEFLY PATIENT'S PAST HISTORY AND DENTAL EXPERIENCE. _____

_____

REVIEWER _____ DATE _____