MEDICAL HISTORY (UNDER 14)

Patient's Name: | Preferred Name:

Date of Birth: / / | Sex: __Male __Female

Parent's/Guardian's Name | Relationship to Patient:

Have you (the parent/guardian) or the patient had any of the following diseases or problems?
__ Active Tuberculosis
__ Persistent cough greater than a three-week duration
__ Cough that produces blood
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had history of, or conditions related to, any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder
- ☐ Bleeding disorders
- ☐ Bones/Joint
- ☐ Cancer
- ☐ Cerabral Palsy
- ☐ Tuburculosis
- ☐ Chicken Pox
- ☐ Chronic Sinusitis
- ☐ Diabetes
- ☐ Ear Aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth Problems
- ☐ Hearing
- ☐ Veneral Disease (HPV)
- ☐ Heart
- ☐ Hepatitis
- ☐ HIV+/AIDS
- ☐ Immunizations
- ☐ Kidney
- ☐ Latex allergy
- ☐ Liver
- ☐ Measles
- ☐ Other
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sickle cell
- ☐ Thyroid
- ☐ Tobacco/Drug Use

Please list the name and phone number of the child's physician:
Name of Physician_____ Phone_____

CIRCLE THE APPROPRIATE ANSWER - **IF YES PLEASE EXPLAIN**

1) YES NO Is the child taking any medications?
2) YES NO Is the child allergic to medications?
3) YES NO Is the child allergic to anything else?
4) YES NO Has the child ever had a serious illness?
5) YES NO Has the child ever been hospitalized?
6) YES NO Does the child have a history of any other illnesses?
7) YES NO Has the child ever received general anesthetic?
8) YES NO Does the child have any inherited problems?
9) YES NO Does the child have any speech difficulties?
10) YES NO Has the child ever had a blood transfusion?
11) YES NO Is the child physically, mentally, or emotionally impaired?
12) YES NO Does the child experience excessive bleeding when cut?
13) YES NO Is the child currently being treated for any illness?
14) YES NO Is this the child's first visit to a dentist?
15) YES NO Has the child had any problem with dental treatment in the past?
16) YES NO Has the child ever had dental radiographs?
17) YES NO Has the child ever suffered any injuries to the mouth, head or teeth?
18) YES NO Has the child had any problems with the eruption or shedding of teeth?
19) YES NO Has the child had any orthodontic treatment?
20) YES NO Does the child take fluoride supplements?
21) YES NO Is fluoride toothpaste used?
22) YES NO Does the child suck his/her thumb, fingers or pacifier?
23) YES NO Does the child participate in active recreational activities?
24) How would you describe the child's eating habits?
25) What type of water does your child drink?
26) How many times are the child's teeth brushed per day? _____ When?_____
27) At what age did the child stop bottle feeding? _____ Breast feeding? _____

NOTE: Both clinician and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature_____ Date_____

Clinician Only Comments _____
_____
_____
_____
_____

Reviewed By: Date:

NORTHWOODS DENTISTRY