

MEDICAL INFORMATION

Have you/your child experienced the following medical problems?

For office use only

Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mononucleosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Polio	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Intestinal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Bone Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous/Emotional Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Endocrine Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	High or Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
HIV Positive	Yes <input type="checkbox"/> No <input type="checkbox"/>	Problems with Wound Healing	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic/Scarlet Fever?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Tumors or Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatism or Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is Patient Under Medical Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Fainting or Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Any Broken Bones	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the Patient have a drug addiction	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Prolonged Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the Patient Pregnant at this time	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Yellow Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the Patient Smoke	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Radiation Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the Patient ever had Fever Blisters	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Chemical Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the Patient in Good Health	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

If female, has Menstruation begun? Yes No

Are you aware of any other disease, condition, or problem not listed above that we should know about? Yes No

Please List _____

Is the Patient currently taking any medications? Yes <input type="checkbox"/> No <input type="checkbox"/> Please list all medications: _____ _____ _____	Is the Patient allergic to anything? Yes <input type="checkbox"/> No <input type="checkbox"/> Please list all allergies: _____ _____ _____
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DENTAL HISTORY

Name of General Dentist _____ Date last seen _____ Phone # _____

Has the Patient Seen a General Dentist in the Last Year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Any Pain, Clicking, or Discomfort in or Near the Ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>	For office use only
Has the Mouth, Face, or teeth been Injured by a Fall or Accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Have You been Informed of Missing or Extra Permanent Teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Are You Aware of Any "Gum" Problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Has a Physician or Dentist Advised Antibiotics Before a Dental Exam?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Have the Patient's Tonsils or Adenoids Been Removed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Does the Patient Have or Ever Had Any of the Following Habits?		
Cheek, Tongue, or Lip Chewing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clenching Teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>
Finger Nail Biting?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tongue Thrusting? Yes <input type="checkbox"/> No <input type="checkbox"/>
Thumb Sucking?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Grinding Teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>
Mouth Breathing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech Problems? Yes <input type="checkbox"/> No <input type="checkbox"/>

I understand the information given is correct and will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.

Signature (Parent's Signature if minor)

(Date)