DATE: _____

CURRENT MEDICAL HISTORY:

YOUTH/ TEEN MEDICAL/DENTAL HISTORY

Has child been a patient in the hospital during the past two years? ..... Yes/No
Has child been under the care of a medical doctor during the past two years? If "Yes", reason: ..... Yes/No

Physician's Name_____ Address_____ Phone_____
Has child taken any medication or drugs in the past two years? ..... Yes/No
Is child now taking any medication, drugs or pills? If yes, please list below: ..... Yes/No
Is child allergic to or ever reacted adversely to any medication or substance? If yes, please list below: ..... Yes/No
* Please list any known allergies.

ALLERGIES

NONE _____
PENICILLIN ..... YES ____ NO ____
CODEINE ..... YES ____ NO ____
ASPIRIN ..... YES ____ NO ____
IBUPROFEN ..... YES ____ NO ____
TETRACYCLINE ..... YES ____ NO ____
OTHER _____

CURRENT MEDICATION

DRUG	DOSE	REASON TAKING

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes / No	Stroke	Yes / No	Hepatitis A (infectious)	Yes / No
Heart Disease or Attack	Yes / No	Artificial Joints (Hip, Knee, etc.)	Yes / No	Hepatitis B (serum)	Yes / No
Angina Pectoris	Yes / No	Kidney Trouble	Yes / No	Venereal Disease	Yes / No
Congenital Heart Disease	Yes / No	Ulcers	Yes / No	A.I.D.S.	Yes / No
Heart Murmur	Yes / No	Diabetes	Yes / No	H.I.V. Positive	Yes / No
High Blood Pressure	Yes / No	Thyroid Problems	Yes / No	Cold Sores/Fever Blisters	Yes / No
Arteriosclerosis	Yes / No	Glaucoma	Yes / No	Blood Transfusion	Yes / No
Mitral Valve Prolapse	Yes / No	Cosmetic Surgery	Yes / No	Hemophilia	Yes / No
Artificial Heart Valve	Yes / No	Emphysema	Yes / No	Anemia	Yes / No
Heart Pacemaker	Yes / No	Chronic Cough	Yes / No	Sickle Cell Disease	Yes / No
Heart Surgery	Yes / No	Tuberculosis	Yes / No	Bruise Easily	Yes / No
Rheumatic Fever	Yes / No	Asthma	Yes / No	Liver Disease	Yes / No
Arthritis	Yes / No	Hay Fever	Yes / No	Yellow Jaundice	Yes / No
Rheumatism	Yes / No	Allergies or Hives	Yes / No	Epilepsy or Seizures	Yes / No
Pain in Jaw Joints	Yes / No	Sinus Trouble	Yes / No	Fainting or Dizzy Spells	Yes / No
Cortisone Medicine	Yes / No	Radiation Therapy	Yes / No	Nervousness	Yes / No
Drug Addiction	Yes / No	Chemotherapy	Yes / No	Psychiatric Treatment	Yes / No
Head or Jaw Injuries	Yes / No	Malignancies	Yes / No	Hearing Loss	Yes / No

Does child have or has child had any disease, condition, or problems not listed? If yes, please list: ..... Yes___No____

Do you have any reason to suspect child is not in good health? Please explain. ..... Yes___No____

DENTAL HISTORY

PURPOSE OF TODAY'S VISIT _____
DATE OF LAST VISIT TO A DENTIST _____
HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS ..... Yes No
ANY UNHAPPY DENTAL EXPERIENCES? ..... Yes No
ANY INJURIES TO MOUTH-TEETH-HEAD? ..... Yes No
ANY MOUTH HABITS, (Thumbsucking, Nail Biting, Mouth Breathing)? ..... Yes No
NURSING BOTTLE HABITS, (Pacifier, etc.)? ..... Yes No
ANY UNUSUAL SPEECH HABITS? ..... Yes No
ANY LOST TEETH? ..... Yes No
ORTHODONTIC APPLIANCES WORN PRESENT OR PAST? ..... Yes No
DOES YOUR CHILD BRUSH TEETH DAILY? ..... Yes No
DO YOU ASSIST CHILD WITH TOOTH BRUSHING? ..... Yes No
HOW OFTEN? _____
IS DENTAL FLOSS OR DISCLOSING TABLETS USED? ..... Yes No
IS FLUORIDE TAKEN IN ANY FORM? ..... Yes No
CHILD'S ATTITUDE TO DENTISTRY:
DO YOU DESIRE COMPLETE DENTAL SERVICE FOR THE CHILD? ..... Yes No
THE ABOVE INFORMATION IS TRUE AND ACCURATE. (Parent or Guardian) _____
SIGNATURE