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PATIENT MEDICAL HISTORY

Child's Name: _____ **Birthdate:** _____ **Age:** _____ **Gender: M / F**

Name and address of physician: _____

Date of your child's last medical exam: _____

Findings? _____

Does child have any illness now? _____

Has your child ever been hospitalized? () yes () no If so, when? _____

Has your child ever had surgery? () yes () no If so, when/what reason? _____

Is your child presently under a physician's care? () yes () no If so, for what? _____

Allergic to any medication or allergic to anything else? _____ Type of Reaction? _____

Taking any medicine? _____ Explain: _____

Dose of medicine: _____

Has child had any history of: (circle those that apply)

- | | | | |
|------------------------------------|----------------------------|-----------------------|----------------------------------|
| AIDS | Breathing Problems | Eye or Sight Problems | Liver Disease |
| Anemia | Congenital Birth Defects | Excessive Bleeding | Lung Disease |
| Asthma | Convulsions/Seizures | Hearing Problem | Mental Retardation |
| Bacterial /Viral Infection | Diabetes | Heart Murmurs | Recurrent Headaches |
| Behavioral Problems | Digestive System Disorders | Heart Trouble | Rheumatic Fever |
| Blood Disease | Emotional Problem | Jaundice | Speech Impediment |
| Blood Transfusions | Endocrine System Disorder | Kidney Problems | Temporal Mandibular Joint Probs. |
| | Epilepsy | Learning Problems | Tuberculosis |
| Dates of Blood Transfusions: _____ | | | Tumors/Cancer |

Others (please list): _____

Is this: First visit to a dentist? () yes () no An emergency? () yes () no

What is your reason for bringing your child in for dental care? _____

Date of last dental visit and x-rays: _____

Is there now or has there ever been any of the following? (please circle)

- | | | | |
|-----------------|--------------------|---------------|----------------|
| Cavities | Toothache | Pain | Broken Tooth |
| Extracted Teeth | Straightened Teeth | Gum Infection | Mouth Injuries |

Does child have a history of: (please circle)

- | | | | |
|---|----------------|-------------|----------------|
| Thumb Sucking | Finger Sucking | Lip Sucking | Teeth Grinding |
| Prolonged use of bottle and/or breast feeding | | Nail Biting | Pacifier |

Has your child had an unfavorable medical or dental experience? () yes () no

If yes, please explain: _____

- Does your child brush regularly? () yes () no
- Does your toothpaste contain fluoride? () yes () no
- Does your child use dental floss? () yes () no
- Is your child's water fluoridated? () yes () no
- Does your child use fluoride rinses or supplements? () yes () no

Please add anything concerning your child's dental or medical history that you feel may be important: Including Social Development (Personality/Temperament): _____

INFORMED CONSENT

The permission of the parent or guardian is necessary for dental treatment of a minor.

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature _____ Relationship to Child _____ Date _____

Reviewed by Doctor _____ Date _____

HEALTH HISTORY UPDATE:

- 1. Comments _____
 Recorded by _____ Date _____
- 2. Comments _____
 Recorded by _____ Date _____
- 3. Comments _____
 Recorded by _____ Date _____
- 4. Comments _____
 Recorded by _____ Date _____