MEDICAL HISTORY

Name: ______________________ DOB: ______________ DDS # ____________

Are you under a physician's care now? ☐ Yes ☐ No ______________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ______________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ______________

Are you taking any medications, pills or drugs? ☐ Yes ☐ No ______________

Are you on a special diet? ☐ Yes ☐ No ______________

Do you have any allergies? ☐ Yes ☐ No ______________

Other, if yes, please explain ______________________________

Do you have or have you had any of the following?

AIDS/HIV Positive	☐Yes	☐ No	Cerebral Palsy	☐Yes	☐ No	Hemophilia	☐Yes	☐ No	Renal Dialysis	☐Yes	☐ No
Alzheimer's	☐Yes	☐ No	Diabetes	☐Yes	☐ No	Hepatitis A	☐Yes	☐ No	Rheumatic Fever	☐Yes	☐ No
Autism	☐Yes	☐ No	Down Syndrome	☐Yes	☐ No	Hepatitis B	☐Yes	☐ No	Rheumatism	☐Yes	☐ No
Angina	☐Yes	☐ No	Emphysema	☐Yes	☐ No	High B.P.	☐Yes	☐ No	Shingles	☐Yes	☐ No
Arthritis	☐Yes	☐ No	Seizures/Epilepsy	☐Yes	☐ No	Rash/Hives	☐Yes	☐ No	Sickle Cell	☐Yes	☐ No
Artificial Joint	☐Yes	☐ No	Fainting Spells	☐Yes	☐ No	Hypoglycemia	☐Yes	☐ No	Sinus Trouble	☐Yes	☐ No
Asthma	☐Yes	☐ No	Frequent Cough	☐Yes	☐ No	Kidney Disease	☐Yes	☐ No	Spina Bifida	☐Yes	☐ No
Blood Disease	☐Yes	☐ No	Intellectual Disability	☐Yes	☐ No	Leukemia	☐Yes	☐ No	Stomach Disease	☐Yes	☐ No
Breathing Problem	☐Yes	☐ No	Herpes	☐Yes	☐ No	Liver Disease	☐Yes	☐ No	Stroke	☐Yes	☐ No
Bruise Easily	☐Yes	☐ No	Glaucoma	☐Yes	☐ No	Lung Disease	☐Yes	☐ No	Swelling of Limbs	☐Yes	☐ No
Cancer	☐Yes	☐ No	Hay Fever	☐Yes	☐ No	Mitral Valve Prolapse	☐Yes	☐ No	Thyroid Disease	☐Yes	☐ No
Chemotherapy	☐Yes	☐ No	Heart Disease	☐Yes	☐ No	Pain in Jaw	☐Yes	☐ No	Tumors	☐Yes	☐ No
Chest Pain	☐Yes	☐ No	Heart Murmur	☐Yes	☐ No	Psychiatric Care	☐Yes	☐ No	Ulcers	☐Yes	☐ No
Cold Sores	☐Yes	☐ No	Radiation Treatment	☐Yes	☐ No	Weight Loss	☐Yes	☐ No	Yellow Jaundice	☐Yes	☐ No

Have you every had any serious illness not listed above? ☐Yes ☐ No, if Yes, please explain: ______________

____

Comments: ______________________________

____

Signature of Parent or Guardian ______________________ Date: ____________