HK DIA PI NI

Patient's Name: ____ Date of Birth: __________________
M/D/Y

All of the information which you provide on this form will be held in the strictest confidence. Although some questions may seem unimportant at this time, they may be vital in an emergency situation. Please answer each question. Use the reverse of this page if you require more space.

MEDICAL HISTORY

OFFICE USE ONLY

MEDICAL HISTORY

1. Is your child under the care of a physician at this time? Yes No
   If yes, why? ____
2. Name of Physician ____
3. Does your child have a health problem? Yes No
   If yes, please explain: ____
4. Has your child ever had a serious illness or been in hospital? Yes No
   If yes, please explain: ____
5. Is your child taking any medications? Yes No
   If so what? ____
6. Is your child allergic to any medicine, drugs or food, or has your child had a bad reaction to any medicine, drug or food? Yes No
   If yes, please list: ____
   ____
7. Does your child have any limitations to physical activities? Yes No
   If yes, please explain: ____
8. Does your child have?
   ◦ problems socializing ◦ temper tantrums ◦ sleeping problems
   ◦ difficulty understanding speech ◦ frequent accidents
9. Is your child: ◦ biological ◦ adopted ◦ foster
10. Were there any problems during the pregnancy or delivery? Yes No
11. Does your child have problems?
    ◦ concentrating ◦ learning ◦ cooperating ◦ understanding
12. Is there a history of domestic violence or spousal abuse? Yes No
13. Are your child's immunizations up to date? Yes No
14. Has your child ever had treatment for any of the following? *Please check those that apply.*
    ◦ Blood-circulatory ◦ Heart ◦ Stomach/Intestine ◦ Bones ◦ Liver ◦ Kidney/Bladder
    ◦ Endocrine Glands ◦ Muscles ◦ Nervous System ◦ Skin ◦ Eyes ◦ Ears, Tonsils / Adenoids
15. Does your child have AIDS or has your child tested HIV positive? Yes No
16. Has your child ever tested positive for hepatitis? Yes No
17. Have you ever been told that your child needs treatment for or has had any of the following conditions? *Please check those that apply.*

◦ Anemia
◦ Allergies
◦ Arthritis
◦ Asthma
◦ Autism
◦ Bleeding Disorders
◦ Blood Transfusions
◦ Brain Injury

◦ Birth Defects
◦ Cancer
◦ Cerebral Palsy
◦ Chicken Pox
◦ Diabetes
◦ Developmental Delay
◦ Emotional Disorders
◦ Epilepsy

◦ Eyesight Problems
◦ Fainting
◦ Hearing Loss
◦ Heart Trouble
◦ Headaches
◦ Hemophilia
◦ Hepatitis
◦ High Blood Pressure

◦ Hyperactivity
◦ Latex Allergy
◦ Leukemia
◦ Liver Problems
◦ Lung Problems
◦ Kidney Problems
◦ Malignant Hyperthermia
◦ Mentally Challenged

◦ Nutritional Deficiency
◦ Pneumonia
◦ Psychiatric Care
◦ Physical Handicap
◦ Speech Problems
◦ Seizures
◦ Scarlet Fever
◦ Scabies

◦ Tuberculosis
◦ OTHER__________
____
____
____
____

Parent or Guardian Signature: ______________________ Date: ____________ Dentist Signature: __________________ Date: __________
M/D/Y M/D/Y