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PEDIATRIC SANDERS DENTISTRY

MEDICAL / DENTAL HISTORY

Patient Name:_____ Birth Date:_____ Gender: ☐Female ☐Male

Physician:_____ Race:_____ Height:_____ Weight:____

Physician Phone:_____

Date of Last Medical Check-up:_____ Immunization Up To Date? ☐ Yes ☐ No

Dental History:

Previous Dentist: _____ Last Dental Visit: _____

Has patient had an injury to the mouth, teeth, or jaw? ☐YES ☐NO Explain:_____

Medical History:

Does patient have / or had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Congenital Heart Defect/Disease	☐	☐	Visual Impairment (excluding glasses)	☐	☐	Eating Disorders
☐	☐	Heart Surgery	☐	☐	Abnormal Bleeding Issues	☐	☐	Born Prematurely
☐	☐	Heart Murmur	☐	☐	Sickle Cell Trait/Disease	☐	☐	Hearing Impairment
☐	☐	High Blood Pressure	☐	☐	Hemophilia/Anemia	☐	☐	Hepatitis A, B, C
☐	☐	Rheumatic Fever	☐	☐	Blood/Blood Product Transfusion	☐	☐	Kidney Problems
☐	☐	Asthma/Breathing Issues	☐	☐	Liver Problems	☐	☐	HIV/AIDS
☐	☐	Cerebral Palsy	☐	☐	Varicella Vaccine / Chicken Pox	☐	☐	Diabetes
☐	☐	Seizures/Convulsions/Epilepsy	☐	☐	Muscle/Joint/Bone Problems	☐	☐	MRSA
☐	☐	Learning/Communication Problems	☐	☐	Thyroid/Glandular Problems	☐	☐	TB / Tuberculosis
☐	☐	Autism Spectrum Disorder	☐	☐	Skin Problems / Hives / Cold Sores	☐	☐	Limited Mobility
☐	☐	ADD/ADHD	☐	☐	Failure to Thrive	☐	☐	Allergies
☐	☐	Anxiety/Depression	☐	☐	Genetic Disorders	☐	☐	Other: _____

If you have checked yes to any of the above, please explain:_____

_____

Is patient taking medications? ☐YES ☐NO Please list all medications and natural remedies.

Medication Name:	Dose:	Frequency of Use:

Has patient had surgery or been hospitalized? ☐YES ☐NO

Hospital Facility:	When:	Reason:

The information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I understand that it is my responsibility to inform Sanders Pediatric Dentistry of any changes in medical status.

Guardian Signature:_____ Relationship to Patient:_____

Date:_____

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