

Medical Health Update

Child's Name: _____ D.O.B.: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (h) _____ (w) _____

In order to provide the best possible dental care for your child, we must be aware of any changes in his/her overall health. Please take a moment to complete the review. Thank you!

My Child's Present Physician is: _____ Phone#: _____

1. Has your child been treated by his/her doctor or other health professional since his/her last visit? _____

If so, for what: _____

2. Has there been a change in your child's overall health since your child's last dental check-up? _____

3. Did your child have a serious injury or hospitalization since your child's last dental check-up? _____

4. Is your child now taking any drugs or medications routinely? _____

Please list medications and dose: _____

5. Does your child have any history of drug reactions, medication allergies, or latex allergy? _____

6. Have you ever been told by a physician to have your child take preventive antibiotics before a dental procedure? _____

7. Does your child have an artificial heart valve, joint replacement, pacemaker, or any other type of surgically-placed prosthesis (pins, plates, rods, or shunts)? _____

8. Has there been a change of your child's primary water source or a change in your child's use of fluoride supplements since his/her last dental checkup? _____

10. Has your child ever had any of the following?

	Yes	No		Yes	No		Yes	No
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD OR BLEEDING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	CEREBRAL PALSY	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT SORE THROATS, EAR ACHES/OTHER INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	BEHAVIORAL/LEARNING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
EYE PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	HEART PROBLEMS OR MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS (TB)	<input type="checkbox"/>	<input type="checkbox"/>	SPEECH OR HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>
BONE OR JOINT PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	HIV (+) / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	BIRTH DEFECTS OR GENETIC DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>
LUNG PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	RECURRENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	INFECTIOUS DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE (GLAND) PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENTAL DELAYS	<input type="checkbox"/>	<input type="checkbox"/>

10. Do you have a particular question about your child's dental care? _____

Comments: _____

Parent's Signature _____ Date _____

Dentist's Summary: _____