Medical History

MUST BE COMPLETED BY PARENT, LEGAL GUARDIAN, OR AUTHORIZED ADULT IF CHILD IS UNDER 18

Patient Name: _____ **Age:**_____ **Date of Birth:**_____ **Gender: M F**

Pediatrician/Primary Care Provider: _____ **Phone Number:**_____

Medical Specialist(s): _____ **Phone Number:** _____

Orthodontist: _____ **Date of last visit:**_____

Immunizations up to date: ☐ **No** ☐ **Yes** ☐ **Do not immunize**

Does your child have or have they ever had any of the following:

Y	N		Y	N		Y	N	
☐	☐	Heart Murmur / Heart Problems	☐	☐	Asthma (Last Attack_____)	☐	☐	Autism / ASD
☐	☐	Allergy to LATEX				☐	☐	Physical Impairments
☐	☐	Allergy to DYES	☐	☐	Cystic Fibrosis	☐	☐	Learning Disability
☐	☐	Shunt	☐	☐	Anemia / Sickle Cell	☐	☐	Developmental Delay
☐	☐	Hemophilia/Bleeding Problems	☐	☐	High Blood Pressure	☐	☐	Behavioral/Personality Disorder
☐	☐	Cancer / Chemo / Radiation	☐	☐	HIV Positive / AIDS	☐	☐	Anxiety/Depression
☐	☐	Organ Transplant _____	☐	☐	ADD / ADHD	☐	☐	MTHFR Deficiency
☐	☐	Kidney Issue / Disease	☐	☐	Hearing Impairment	☐	☐	History of Tuberculosis
☐	☐	Diabetes (Last count_____) Time taken_____)	☐	☐	Acid Reflux / GERD	☐	☐	Dermatologic or Skin Conditions
			☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Sleep Apnea
☐	☐	Liver Issue / Hepatitis	☐	☐	Cerebral Palsy	☐	☐	Strong / Excessive Gag Reflex
☐	☐	Digestive / Bladder Issues	☐	☐	Pregnancy	☐	☐	Seasonal Allergies
☐	☐	Anesthesia Issues	☐	☐	Glaucoma	☐	☐	Other_____

Medicines (Prescription, Over-the-Counter, Herbal): ☐ **No** ☐ **Yes Please list:** _____

_____

Allergies (Medication/Food/Other Product): ☐ **No** ☐ **Yes: Please list:** _____

Does your child require antibiotics prior to dental treatment (heart murmur, shunt, prosthetic device, pins/screws, etc.): ☐ **No** ☐**Yes**

Has your child had: ☐ No ☐Yes **Tonsils Removed** ☐ No ☐Yes **Hospital stays/operations** ☐ No ☐Yes **Pins/Screws If yes to any, please describe with dates:**_____

Has your child been seen, needed to be seen, diagnosed and/or treated by a healthcare provider for any of the following:

☐ **No** ☐**Yes Sickness, fever, congestion, upper respiratory/sinus infection in the last 2 weeks.** ☐ **No** ☐**Yes Ear infection in the last 4 weeks.**

☐ **No** ☐**Yes Ongoing Staph/MRSA infection in the last 4 weeks.** ☐ **No** ☐**Yes Strep throat in the last 2 weeks.**

☐ **No** ☐**Yes Lice, Pink Eye, Poison Ivy/Oak last 2 weeks.** ☐ **No** ☐**Yes Contagious illness in last 4 weeks.**

If yes to any, by whom was your child seen and when:_____

Person Accompanying Child: Are you: ☐**Parent** ☐ **Step-Parent** ☐**Grandparent** ☐**Other (Please specify)** _____

Name (Please Print):_____**Phone:**_____

Do you have any concerns for today's visit? ☐ No ☐Yes **(If yes, please list)** _____

_____

Has your child been seen by another dentist or dental specialists since their last visit here: ☐ **No** ☐**Yes**

If yes, please describe: _____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status, address, phone number, email address or any other personal information. I give Pediatric Dental Specialists, P.A. permission to perform cleaning, x-rays deemed necessary for diagnosis, examination, fluoride treatment, and (sealants if applicable with prior authorization). In case of an emergency, I hereby authorize Pediatric Dental Specialists, P.A. to perform emergency and/or life-saving treatment for my child.

_____	_____	_____	_____
Patient Sign or legal guardian if a minor	Print Name	Relationship	Date

_____ **I give permission to Pediatric Dental Specialists, P. A. to use my child's first name and picture in their website (**www.shermankidsdentists.com) **or social media (i.e. Facebook page, Instagram, etc.) for future promotions and announcements.**_____

For Office Use Only

Medical History Reviewed By_____

Time_____ **Age**_____ **Height**_____ **Weight**_____ **BP**_____ **Pulse**_____ **O2 Sat**_____ **ASA**_____ **TX Y N** Form 16/Rev 12/23