

Bay County Children's Dentistry Clinic

Patient Medical History

PLEASE COMPLETE THIS FORM WITH PATIENT'S INFORMATION ONLY
Thank you for answering the following questions

Is your primary language English? If yes, proceed. If no which language do you speak?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Are you currently under a physician's care?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Are you currently taking any medications?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Do you consume or drink alcoholic beverages? If yes, do you drink 2-3 times a week?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>

Woman Are you...

Are you Pregnant/Trying to get Pregnant? <input type="radio"/> Yes <input type="radio"/> No	Are you Nursing? <input type="radio"/> Yes <input type="radio"/> No	Are you taking Oral Contraceptives? <input type="radio"/> Yes <input type="radio"/> No
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ARE YOU ALLERGIC TO ANYTHING?

Aspirin <input type="radio"/> Yes <input type="radio"/> No	Latex <input type="radio"/> Yes <input type="radio"/> No	Penicillin <input type="radio"/> Yes <input type="radio"/> No	Codeine <input type="radio"/> Yes <input type="radio"/> No
Acrylic <input type="radio"/> Yes <input type="radio"/> No	Metal <input type="radio"/> Yes <input type="radio"/> No	Sulfa Drugs <input type="radio"/> Yes <input type="radio"/> No	Local Anesthetics <input type="radio"/> Yes <input type="radio"/> No
Pine Nuts <input type="radio"/> Yes <input type="radio"/> No	Amoxicillin <input type="radio"/> Yes <input type="radio"/> No		

NO KNOWN ALLERGIES

OTHER If yes

HISTORY

DOES THE PATIENT HAVE OR HAD IN THE PAST, ANY OF THE FOLLOWING?

ADHD/ADD <input type="radio"/> Yes <input type="radio"/> No	Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Autism/Aspergers <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blind <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Throid Disease <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cerebral Palsy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hearing Impaired <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Chest Pain <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Veneral Disease <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaudice <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes

Comments

1. Reason for this dental visit today? If yes
2. Are you currently having any dental pain or problems? Yes No If yes
3. Have you ever experienced any unfavorable reaction from previous dental treatment? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____