325 W. South Boulder Rd. Suite 4
Louisville, Colorado 80027
(303) 604-0710

905 W. 124th Ave. Suite 190
Westminster, Colorado 80234
(303) 280-9036

PATIENT MEDICAL HISTORY

Child's Name: Birthdate: Age: Gender: M / F

Name and address of physician: ____________________

Date of your child's last medical exam: ____________________

Findings? ____________________

Does child have any illness now? ____________________

Has your child ever been hospitalized? ( ) yes ( ) no If so, when? ____________________

Has your child ever had surgery? ( ) yes ( ) no If so, when/what reason? ____________________

Is your child presently under a physician's care? ( ) yes ( ) no If so, for what? ____________________

Allergic to any medication or allergic to anything else? __________ Type of Reaction? ____________________

Taking any medicine? ____________________ Explain: ____________________

Dose of medicine: ____________________

Has child had any history of: (circle those that apply)

AIDS	Breathing Problems	Eye or Sight Problems	Liver Disease
Anemia	Congenital Birth Defects	Excessive Bleeding	Lung Disease
Asthma	Convulsions/Seizures	Hearing Problem	Special Needs
Bacterial /Viral Infection	Diabetes	Heart Murmurs	Recurrent Headaches
Behavioral Problems	Digestive System Disorders	Heart Trouble	Rheumatic Fever
Blood Disease	Emotional Problem	Jaundice	Speech Impediment
Blood Transfusions	Endocrine System Disorder	Kidney Problems	Temporal Mandibular Joint Probs.
	Epilepsy	Learning Problems	Tuberculosis
			Tumors/Cancer

Dates of Blood Transfusions: ____________________

Others (please list): ____________________

Is this: First visit to a dentist? ( ) yes ( ) no An emergency? ( ) yes ( ) no

What is your reason for bringing your child in for dental care? ____________________

Date of last dental visit and x-rays: ____________________

Is there now or has there ever been any of the following? (please circle)

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	Mouth Injuries

Does child have a history of: (please circle)

Thumb Sucking	Finger Sucking	Lip Sucking	Teeth Grinding
Prolonged use of bottle and/or breast feeding		Nail Biting	Pacifier

Has your child had an unfavorable medical or dental experience? ( ) yes ( ) no

If yes, please explain:____

Does your child brush regularly? ( ) yes ( ) no

Does your toothpaste contain fluoride? ( ) yes ( ) no

Does your child use dental floss? ( ) yes ( ) no

Is your child's water fluoridated? ( ) yes ( ) no

Does your child use fluoride rinses or supplements? ( ) yes ( ) no

Please add anything concerning your child's dental or medical history that you feel may be important: Including Social Development (Personality/Temperament):____

____

INFORMED CONSENT

The permission of the parent or guardian is necessary for dental treatment of a minor.

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature _________________________ Relationship to Child _________________ Date ___________

Reviewed by Doctor ____________________ Date _______________

HEALTH HISTORY UPDATE:

1. Comments____
   Recorded by____Date _________________________
2. Comments____
   Recorded by____Date _________________________
3. Comments____
   Recorded by____Date _________________________
4. Comments____
   Recorded by____Date _________________________