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

905 W. 124th Ave. Suite 150
Westminster, Colorado 80234
(303) 280-9036

PATIENT MEDICAL HISTORY

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

Name and address of physician: _____

Date of your child's last medical exam:_____

Findings?_____

Is your child presently under additional care? ( ) yes ( ) no If so, for what?_____

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

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

Please list any allergies (medication or otherwise) _____

Type of Reaction? _____

Please list any medications/supplements (inc dose)?_____

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

ADHD/ADD	Breathing Problems	Eye or Sight Problems	Lung Disease
AIDS/HIV+	Congenital Birth Defects	Excessive Bleeding	MTHFR
Anemia	Convulsions/Seizures	Hearing Problems	Special Needs
Anxiety/Depression	Diabetes	Heart Murmurs	Recurrent Headaches
ASD	Digestive System Disorder	Heart Defect/Arrythmia	Rheumatic Fever
Asthma	Endocrine System Disorder	Kidney Problems	Speech Impediment
Behavioral Problems	Epilepsy	Liver Disease	TMJ Problems
Blood Disease			Tumors/Cancer
Blood Transfusions			

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
Issues with 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 _____