Pediatric Medical History

Linh T. Tran, DDS, PC

Name:______________________________ Date: ____________________
Physician's Name:______________________ Phone #: ____________________
Physician's Address:____________________ Date of Last Visit: ______________
Your child's current physical health is: [ ] Good [ ] Fair [ ] Poor
Is your child taking any prescription/over-the-counter drugs? [ ] Yes [ ] No

Please list each one:____

Has the child ever had any of the following:

Condition			Condition		
Heart Murmur	Y	N	Diabetes/Tuberculosis	Y	N
Congenital Heart Defect	Y	N	Venereal Disease	Y	N
Rheumatic Fever	Y	N	Hemophilia/Abnormal Bleeding	Y	N
HIV+/AIDS	Y	N	Anemia/Leukemia/Sickle Cell	Y	N
Cancer/Chemo/Radiation Tx	Y	N	Asthma/Difficulty Breathing	Y	N
Kidney/Liver Problems	Y	N	Hepatitis/Jaundice/Cirrhosis	Y	N
Sinus Problems	Y	N	Hospitalized for Any Reason	Y	N
Fever Blisters/Cold Sores	Y	N	Any operations	Y	N
Hearing Impairment	Y	N	Adverse Reaction to Anesthetics	Y	N
Emotional/Behavioral Problems	Y	N	Handicaps/Disabilities	Y	N
Epilepsy/Seizures/Fainting	Y	N	Other	Y	N

Please list any serious medical conditions that the child has ever had: ________________
Please list any medicine/drugs the child is allergic to: ______________________

DENTAL HISTORY:
Why did you bring the child to the dentist today? ________________________
Is the child currently in pain? [ ] Yes [ ] No
The child's current dental health is: [ ] Good [ ] Fair [ ] Poor
Does the child brush daily? [ ] Yes [ ] No Floss daily? [ ] Yes [ ] No
Has the child ever had a difficult problem associated with any previous dental work? [ ] Yes [ ] No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need during diagnosis and treatment.

______________________________ ____________________
Signature Date

Notes:

Dr.'s signature:________________________ Date:________________