# Medical History Form

CUADRA PEDIATRIC DENTISTRY LLC

Child's Name _____

Child's Birthdate ____/____/____

Child's Physician_____ Phone # (____) _____-_____

Does child have regular medical exams? ☐Yes/ ☐ No Are immunizations up to date? ☐ Yes/ ☐ No

Is child taking any medications? ☐ Yes/ ☐ No If yes, what? _____

_____

Child's Allergies: ☐ Latex ☐Penicillin/Amoxicillin ☐ Nickel ☐ Dental Anesthetics ☐ Aspirin ☐ Food Allergies ☐ Other(s):

_____

Does child currently have, or has child ever had, any of the following diseases, medical conditions, or procedures?

| | | |
|---|---|---|
| ☐ Heart Murmur | ☐ Tonsillitis | ☐ Brain Injury |
| ☐ Rheumatic Fever | ☐Asthma/Difficulty Breathing | ☐Autism |
| ☐ Artificial Heart Valves | circle: Mild/Moderate/Severe | ☐ Liver/Kidney/Organ |
| ☐ Congenital Heart Defect | ☐ Respiratory Problems | ☐ HIV + AIDS |
| ☐ Physically Challenged | ☐ Blood Transfusion(s) | ☐ Tuberculosis (TB) |
| ☐ Surgeries/Operations | ☐ Leukemia/Anemia | ☐ Psychiatric Problems |
| ☐ Cancer/Tumors | ☐ Diabetes/Hypoglycemia | ☐ Hyperactive |
| ☐ Chemotherapy | ☐ Hemophilia | ☐ ADD/ADHD |
| ☐ Jaw Problems TMJ/TMD | ☐ Abnormal Bleeding | ☐ Fainting/Seizures/Epilepsy |
| ☐ Hearing Problems | ☐ Cleft Lip/Palate | ☐ Cerebral Palsy |
| ☐ Sickle Cell or Trait (please specify) | ☐ Birth Defects | ☐ Down Syndrome |

Please list any other medical conditions, present or past, including any hospitalizations:

_____

Child's Dental Information

Reason for today's visit: ☐ Cleaning/Exam ☐ Treatment ☐ Emergency ☐ Consultation

Is your child in pain? ☐ No ☐ Yes If yes, for how long?_____

Does your child require pre-medication with antibiotics for treatment? ☐ Yes ☐ No

Previous Dentist _____Last Dental Visit ____/____/____

Times per day child brushes _____ Is child's water fluoridated? ☐ Yes ☐ No ☐ Don't Know

Does child do any of the following? ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting ☐ Tooth Grinding/Clenching

Parent/Guardian Signature _____ Date ____/____/_____