For the following medical history questions, **please (x) whichever applies**. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your child's health. This information is vital to allow us to provide appropriate care for your child. This clinic does not use this information to discriminate.

WE CANNOT SEE YOUR CHILD IF THIS IS NOT COMPLETE!

Medical History

Please check yes, no, or unsure if your child has/had any of the following conditions:

Yes	No	Unsure		Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Allergies (list below)	☐	☐	☐	Hepatitis	☐	☐	☐	Tumors
☐	☐	☐	Anemia	☐	☐	☐	Herpes	☐	☐	☐	Radiation Treatment
☐	☐	☐	Asthma	☐	☐	☐	High Blood Pressure	☐	☐	☐	Chronic Ear Infections
☐	☐	☐	Autism	☐	☐	☐	HIV/AIDS	☐	☐	☐	Pregnant (at this time)
☐	☐	☐	ADHD/ADD	☐	☐	☐	Hyperactivity	☐	☐	☐	Sexually Transmitted Diseases
☐	☐	☐	Birth Defects	☐	☐	☐	Kidney Disease	☐	☐	☐	Hearing Loss/Impairment
☐	☐	☐	Bleeding Problems	☐	☐	☐	Learning Disabilities				
☐	☐	☐	Blood Disorders	☐	☐	☐	Liver Disease	☐	☐	☐	Heart Conditions/Murmur
☐	☐	☐	Cancer	☐	☐	☐	Mental Disability	☐	☐	☐	If yes to heart murmur is an antibiotic required before dental appointments**? If you are unsure, we will need confirmation from your cardiologist before treatment.**
☐	☐	☐	Cerebral Palsy	☐	☐	☐	Muscular Dystrophy				
☐	☐	☐	Developmental Delay	☐	☐	☐	Psychiatric Problems				
☐	☐	☐	Diabetes	☐	☐	☐	Rheumatic Fever				
☐	☐	☐	Downs Syndrome	☐	☐	☐	Seizures				
☐	☐	☐	Emotional Problems	☐	☐	☐	Sickle Cell Anemia	☐	☐	☐	Jaundice (not at birth)
☐	☐	☐	Epilepsy	☐	☐	☐	Skin Disorders	☐	☐	☐	Delayed Speech Development
☐	☐	☐	Fainting Spells	☐	☐	☐	Tuberculosis				

Please explain all "Yes" or "Unsure" responses:
Please list any other problems/conditions/allergies your child may have

Current Medication List

Is your child taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? ☐ Yes ☐ No If yes, please list medications.

Medication	Reason for Taking	How Much	How Often

To the best of my knowledge, the indicated health history remains current.
I understand that any change in the patient's health or medication requires that an updated form be completed.
I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
I certify that I have read and understand the above.
I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____/_____ Date____/____/_____

(Print) parent/guardian (Signature) parent/guardian

Emergency Contact Information:

Name: _____ Relationship: _____

Emergency Number: _____