

Medical History Form

Nancy T. Simons, D.D.S.

Child's Name _____ Date _____

Date of Birth _____ / _____ / _____
Month Day Year

DENTAL HISTORY

Has your child had dental treatment elsewhere? Yes _____ No _____ Name of Previous Dentist _____
What was his/her reaction? _____

When was his/her last dental visit? _____ Were X-rays taken? _____

Does your child have any dental complaints? _____
How long? _____

Does your child suck a finger, thumb, pacifier? _____

Does your child sleep with a bottle? _____ How long? _____
Does/Did your child breastfeed? _____ How long? _____

Is there a history of TMJ (jaw joint) dysfunction? _____

Has your child had any trauma involving the face, mouth or chin? _____

MEDICAL HISTORY

Has your child ever had:	YES	NO		YES	NO		YES	NO
Abnormal Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	An Operation/Hospital Stay	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	History of Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Constant Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>

Has your child tested positive for HIV? _____

Does your child have a physical/mental/emotional handicap? _____

Does your child have any other medical conditions? _____

Is your child taking any medications? _____

Name of physician _____ Phone (_____) _____

May we contact your physician for additional information, if necessary? _____

Is your child allergic to: YES NO

Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	