

PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: _____ Phone: _____

Does the patient see any medical specialists? Yes No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions. Yes No ?

Is the patient currently being treated for any condition(s) or illness(es)? If yes, what is the illness and when did it start?
Has the patient ever had a serious illness? If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized? When and why?
Has the patient ever been given a general anesthetic?
Has the patient ever had a blood transfusion?
Does the patient experience excessive bleeding when cut?
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions? If yes, please explain.
Does the patient have any genetic (inherited) conditions? If yes, please explain.
Does the patient have any speech difficulties? If yes, please explain.
How would you describe the patient's eating habits?
Is the patient up-to-date with immunizations related to childhood diseases (tetanus, measles, mumps, etc.)? Yes No
If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? Immunized Not immunized
Over the past two weeks, has the patient felt connected to the world around them? Yes No ?

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- ADD/ADHD Chicken Pox Hepatitis Seizures
 Alcohol/Drugs Chronic sinusitis HIV/AIDS Sexually transmitted infection (STI)
 Anemia Diabetes Immunizations Sickle Cell Anemia
 Arthritis Ear aches Kidney problems Thyroid issues
 Asthma Epilepsy Liver problems Tobacco/Vaping
 Bladder problems Fainting Measles Tuberculosis
 Bleeding disorders Growth problems Mononucleosis Other: _____
 Bone/Joint issues Hearing problems Mumps
 Cancer Heart Issue Pregnancy (teens)
 Cerebral Palsy Heart Murmur Rheumatic Fever

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions. Yes No ?

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?
If yes, please list them here: _____
Is the patient taking GLP-1 Glucagon-Like Peptide-1 medication?
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?
If yes, please list those medications and what happened when the patient took them: _____
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.?
If yes, please describe the allergy and the reaction: _____

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.
I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.
Signature of Parent/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____
Office Use Only:
 Medical Alert Premedication Allergies Anesthesia
Reviewed by: _____ Date: _____

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