Silverdale Dental Center
For Kids

PATIENT MEDICAL HISTORY

Patient Name: _____Age:____Birthdate: _____

1. Child's Physician Name:_____ Phone# (___)_____
2. Date of last medical exam:_____ Nature of exam: _____
3. Describe child's general health:_____
4. Is your child undergoing the care of a physician or specialist for a specific reason? ❑**YES** ❑**NO**
   If **YES** please explain:_____
   Name of physician or specialist:_____
5. Has your child been hospitalized before? ❑**YES** ❑**NO**
   If **YES** please explain:_____
6. Has your child had a serious illness or injury? ❑**YES** ❑**NO**
   If **YES** please explain:_____
7. Is your child limited in activity due to a physical or mental condition? ❑**YES** ❑**NO**
   If **YES** please explain:_____
8. Does your child have any bleeding conditions or does anyone in your family have a history of any bleeding conditions?
   ❑**YES** ❑**NO** If **YES** please explain: _____
9. Does your child exercise regularly? ❑**YES** ❑**NO**
   If **YES** please explain: _____
10. Does your child smoke or use tobacco products? ❑**YES** ❑**NO**
    If **YES** please explain: _____
11. Does your child take birth control? ❑**YES** ❑**NO**
    If **YES** please explain: _____
12. Is there a disease/condition/problem your child may have that may affect the success in dental treatment? ❑**YES** ❑**NO**
    If **YES** please explain:_____
13. Please list any of the medications your child is taking: _____
    _____
14. Is your child allergic to any of the following?
    ❑**Aspirin** ❑**Codeine** ❑**Latex** ❑**Metal** ❑**Rubber** ❑**Red Dye** ❑**Antibiotics** (which ones)_____
    Please list **ALL** other allergies including **FOOD** allergies: _____
    _____
15. Please indicate if your child has had a history of: (Please check all that apply)

❑ADHD/ADD	❑Chemo/Radiation	❑Eyes/Vision	❑Premature Birth
❑Anemia	❑Chromosomal Abnormality	❑Feeding tube	❑Rheumatic Fever
❑Anxiety	❑Cleft Lip/Palate	❑Headaches	❑Seizures
❑Aspiration Risk	❑Congenital Heart Problem	❑Heart Disease	❑Sinus/Sinusitis
❑Asthma/Reactive Airway	❑Crohns/Colitis	❑Heart Surgery	❑Speech Delay
❑Autism/Aspberger Syndrome	❑Developmental Delay	❑Hearing Aids/Impaired	❑Spina Bifida
	❑Diabetes	❑Hepatitis A B C	❑STD
❑Bacterial Endocarditis	❑Down Syndrome	❑HIV/AIDS	❑Tuberculosis (TB)
❑Bleeding Disorder	❑Eating disorder	❑Hydrocephalus	❑VA Shunt
❑Cancer/Tumors	❑Endocrine/Thyroid	❑Kidney/Liver Disease	❑Other_____
❑Cerebral Palsy	❑Epilepsy	❑Psychiatric Care	

Please Explain:
_____

16. Would you like to speak privately with the doctor regarding your child? ❑**YES** ❑**NO**

Signature/Digital Initials: _____ **Date:** _____

Relationship: _____