Medical History Update

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____ **CHART #:** _____

Have there been any changes in your medical history, including any medications that you take, since you last completed this form? ☐ Yes ☐ No

HEALTH HISTORY

YES	NO	CONDITIONS
☐	☐	Are immunizations current?
Has your child been diagnosed and/or treated for any of the following?		
☐	☐	Abnormal Bleeding/Hemophilia
☐	☐	ADD/ADHD
☐	☐	Anemia
☐	☐	Allergies (Seasonal) or Hay Fever
☐	☐	Asthma/Reactive Airway Disease
☐	☐	Autism/ASD
☐	☐	Bone/Joint Problems
☐	☐	Cancer/Tumor/Leukemia
☐	☐	Cleft Lip and/or Palate
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing

YES	NO	CONDITIONS
☐	☐	Hearing/Vision Impairment
☐	☐	Heart Disease/Murmur
☐	☐	HIV+/AIDS/Immune Disorder
☐	☐	Kidney Problems
☐	☐	Liver Problems
☐	☐	Psychiatric/Mental Health
☐	☐	Rheumatic/Scarlet Fever
☐	☐	Sickle Cell Disease/Trait
☐	☐	Seizures/Epilepsy/Convulsions
☐	☐	Sinus Problems
☐	☐	Stomach/GI Disorders
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Kidney/Liver Problems

YES	NO	CONDITIONS
☐	☐	Allergy to Medications
☐	☐	Allergies to Foods
☐	☐	Allergy to Latex or Other Materials
☐	☐	Taking Medications

YES	NO	CONDITIONS
☐	☐	Premature Birth
☐	☐	Serious Illness
☐	☐	Hospitalization
☐	☐	Surgery

If Yes, List Allergies _____

_____

If Yes, List Current Medications _____

_____

If Yes, please describe _____

_____

_____

_____

Are you happy with the child's prior dental experiences? ☐ Yes ☐ No

Has the child had a previous unfavorable or fearful dental or medical experience? ☐ Yes ☐ No

If Yes, please describe _____

Describe your child's temperament _____

Name one thing he/she really likes _____

PHYSICIAN INFORMATION

Pediatrician/Physician Name _____

Address _____

Phone _____

Date of Last Visit _____

I hereby certify that I have read the foregoing, that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of changes to the child's medical status. **I authorize the doctors and staff at Seahorse Kids Dental to perform on my child x-rays, examination, professional cleaning, fluoride treatment and I further grant permission to perform recommended dental treatment mutually agreed upon by me, as presented in the treatment plan.**

Name of Parent/Guardian _____ Signature _____ Date _____

Doctor Signature _____ Date _____