

# 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
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<input type="checkbox"/>	<input type="checkbox"/>	Are immunizations current?
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Has your child been diagnosed and/or treated for any of the following?

<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding/Hemophilia
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<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
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<input type="checkbox"/>	<input type="checkbox"/>	Anemia
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<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Seasonal) or Hay Fever
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<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Reactive Airway Disease
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<input type="checkbox"/>	<input type="checkbox"/>	Autism/ASD
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<input type="checkbox"/>	<input type="checkbox"/>	Bone/Joint Problems
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<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor/Leukemia
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<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip and/or Palate
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<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
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<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
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<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
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YES	NO	CONDITIONS
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<input type="checkbox"/>	<input type="checkbox"/>	Hearing/Vision Impairment
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<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Murmur
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<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS/Immune Disorder
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<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
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<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems
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<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Mental Health
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<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever
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<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease/Trait
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<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy/Convulsions
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<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
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<input type="checkbox"/>	<input type="checkbox"/>	Stomach/GI Disorders
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<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
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<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
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<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems
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YES	NO	CONDITIONS
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<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Medications
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<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Foods
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<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Latex or Other Materials
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<input type="checkbox"/>	<input type="checkbox"/>	Taking Medications
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If Yes, List Allergies \_\_\_\_\_

\_\_\_\_\_

If Yes, List Current Medications \_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_

YES	NO	CONDITIONS
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<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth
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<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness
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<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization
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<input type="checkbox"/>	<input type="checkbox"/>	Surgery
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If Yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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 \_\_\_\_\_