Crabapple
Pediatric Dentistry & Orthodontics

## PATIENT MEDICAL, DENTAL, HEALTH AND MEDICATION HISTORY

**PATIENT NAME:** **BIRTHDAY:** / /

**PLEASE CIRCLE ANY CONDITION FOR WHICH THE PATIENT HAS EXPERIENCED, BEEN DIAGNOSED OR HAS BEEN TREATED FOR:**

| | | | | |
|---|---|---|---|---|
| ADHD | Adrenal Disorder | Aids / HIV | Allergies (Seasonal) | Anemia / Sickle Cell |
| Antibiotics | Anxiety / Nervous | Arthritis | Asperger's | Asthma |
| Autism | Autoimmune Problems | Bleeding Disorder | Bulimia | Bone Disorders |
| Cancer | Cerebral Palsy | Chest Pains | Chocolate Allergy | Chronic Neck Pain |
| Clicking of Jaw | Cold Sores/Herpes | Congenital Birth Defect | Diabetes | Developmental Disability |
| Ear / Eye Disorder | Endocrine Problems | Emotional Disorders | Epilepsy | Fainting, Dizziness |
| Gag Reflex | Glaucoma | Headaches | Heart Condition | Hepatitis A B C |
| Immune Problems | Intestinal Problems | Kidney Problems | Latex Allergy | Learning Difficulty |
| Liver Disease | Lung Disorder | High / Low Blood Pressure | Mouth Breathing/Problem | Muscular Disorders |
| Nervous Disorders | Nut Allergy | Organ Transplant / Pins / Rods | Painful Chewing | Penicillin |
| Periodontal Problems | Pregnant (Currently) | Pneumonia | Prolonged Bleeding | Rheumatic Fever |
| Scoliosis | Seizures | Sickle Cell Anemia | Stomach Problem | Speech Problems |
| Thumb / Finger Habit | Thyroid Problems | TMJ Problems | Tooth Grinding | Tuberculosis |

YES NO Any Disease, Allergies Or Problems Not Mentioned Above?

If YES Please Explain_____

YES NO Is The Patient Under Routine Care Of A Physician?

If YES Please Explain_____

YES NO Does The Patient Have Or Has Had Any Heart Condition, Murmur Or Heart Surgery?

If YES Please Explain_____

YES NO Does The Patient Have Any Drug Allergies Or Reaction To Any Drug?

If YES Please Explain_____

YES NO Does The Patient Take Any Medications On A Regular Basis Or Currently Taking Any Medication? (Ex: Antibiotics, Etc.)

If YES Please List_____

YES NO Has The Patient EVER Been Admitted In A Hospital / Emergency Room For Any Reason?

If YES Please Explain_____

YES NO Has The Patient Ever Seen A Orthodontist Or Dentist For Treatment Or Consult?

If YES Please Explain_____

YES NO Has The Patient Ever Bumped Or Had Trauma To Any Teeth?

If YES Please Explain_____

YES NO Has The Patient Ever Had A Traumatic Medical Or Dental Experience?

If YES Please Explain_____

YES NO Is There Anything Else You Would Like Us To Know About The Patient Being Seen For Treatment Today?

If YES please explain_____

YES NO Does The Patient Drink Fluoridated Water, Take Fluoride Tablets, Fluoride Drops, Or Vitamins That Contain Fluoride?

YES NO Have The Tonsils And Adenoids Been Removed?

If YES When? _____

### * * * YOUNG CHILDREN ONLY * * *

YES NO Does Your Child Have A Bottle To Go To Sleep?

YES NO Is Your Child A Toothpaste Eater?

YES NO Does Your Child Suck On Their Thumb, Fingers, Pacifier, Blanket Or Something Else? If YES Please Explain_____

**NOTE:** **Both Doctor And Patient Are Encouraged To Discuss Any And All Relevant Patient Health Issues Prior To Treatment.**

I certify that I have read and understand the above; I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, orthodontist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. It is my responsibility to notify your office of any change in the above information prior to any appointment.

**PLEASE SIGN AND DATE:** **I HAVE READ AND UNDERSTAND THE FOLLOWING INFORMATION.**

**A Notice OF Our Office Policies, Privacy Practices And Consent For Treatment Is Given Upon Request At Your Initial New Patient Exam.**

Patient / Parent or Guardian's Signature: _____ Date: _____/_____/_____

Responsible Party Name, Please Print: _____

Relationship To Patient? Mother / Father / Self / Guardian / Grandparent / Stepparent / Other _____