Time 11:51 AM | Dr. Katarzyna J Lindhorst | Date 9/14/2016

Smiles For Kids Medical History Form(Copy)(Copy)(Copy)

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

General Questions

Please provide name and number of your child's pediatrician AND any other doctor he/she is seeing.	☐	If yes
Has your child ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Is your child on a special diet?	○ Yes ○ No	If yes

Allergies and Medications

Is your child allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Dental Anesthetics
☐ Demerol or Phenergan	☐ Valium		

If answered YES to any of the above, please describe the reaction	☐	If yes
Other Allergies (environmental/nuts/animals)?	○ Yes ○ No	If yes
Is your child taking any medications, inhalers, vitamins, pills or drugs?	○ Yes ○ No	If yes

Current Health

Does your child have, or had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No	Anaphylaxis	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Anemia	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No
Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No	Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Liver Disease	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No
Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No
Ulcers	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Jaundice (not at birth)	○ Yes ○ No
ADD/ADHD	○ Yes ○ No	Autism Spectrum	○ Yes ○ No				

If you answered YES to any of the above questions, please elaborate.	☐	If yes
Has your child ever had any serious illness, condition or syndrome not listed above?	○ Yes ○ No	If yes

Dental Questions

Has your child had any "bad" dental experience in the past?	○ Yes ○ No	If yes
Has your child experienced any complications following dental treatment?	○ Yes ○ No	If yes
Has your child experienced prolonged bleeding following dental treatment?	○ Yes ○ No	If yes
Has your child experienced any clicking or pain in jaw joint?	○ Yes ○ No	If yes
Do you have family history of jaw surgery, missing teeth or other dental issues?	○ Yes ○ No	If yes
Has your child had any dental trauma or injury to jaw or teeth?	○ Yes ○ No	If yes

Teenagers and Young Adults

WOMEN: Are you...

Pregnant/Trying to get pregnant? ○ Yes ○ No	Nursing? ○ Yes ○ No	Taking oral contraceptives? ○ Yes ○ No

Do you drink sodas or energy drinks like Gatorade? (If YES please indicate type and frequency)	○ Yes ○ No	If yes
Do you use tobacco? (If YES please indicate type and frequency)	○ Yes ○ No	If yes
Do you use any recreational drugs? (If YES please indicate type and frequency)	○ Yes ○ No	If yes
Do you drink alcohol? (If YES please indicate type and frequency)	○ Yes ○ No	If yes
Do you currently have or had a history of any eating disorders? (If YES please explain)	○ Yes ○ No	If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____