Ponzio Dental Child Medical History 2017

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, c

Is your child under a physician's care now?	◯ Yes ◯ No	If yes
Has your child ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Has your child ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Is your child taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes

Is your child allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

Artifical Heart Valve	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Seasonal Allergies	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Congenital Heart Disorder or Murmur	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Anxiety	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
ADD/ADHD	◯ Yes ◯ No				

Has your child ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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:_____