Growing Smiles Pediatric Dentistry

Patient Medical History

Patient Name: ____ Today's Date: _______________

Date of Birth: ____________________________ Social Security No.: _____________________________

Physician's Name: __________________________ Physician's Phone: ____________________________

Sex (circle one): M F

If female, please answer the following:

Y N	Y N
☐ ☐ Are you taking Birth Control Pills?	☐ ☐ Do you smoke or use tobacco?
☐ ☐ Are you pregnant? If yes, # of weeks _____	
☐ ☐ Are you nursing?	Height _________ Weight _________

Y N Conditions	Y N Conditions	Y N Conditions
☐ ☐ Environmental Allergies	☐ ☐ Eczema or Psoriasis	☐ ☐ Strep Throat or Tonsillitis
☐ ☐ Sinus Problems	☐ ☐ Emotional / Behavioral Problems	☐ ☐ Tuberculosis
☐ ☐ Artificial Heart Valve	☐ ☐ Learning Disorder	☐ ☐ Ulcers
☐ ☐ Heart Murmur	☐ ☐ ADHD	■ ☐ Treatment Consent Given
☐ ☐ Heart Surgery	☐ ☐ Autistic	■ ☐ Nitrous Oxide Consent
☐ ☐ Pace Maker	☐ ☐ Psychiatric Problems	Given
☐ ☐ Mitral Valve Prolapse	☐ ☐ Physical Abuse	
☐ ☐ Congenital Heart Defect	☐ ☐ Fainting Spells	Y N Allergies
☐ ☐ Asthma	☐ ☐ Fever Blisters	☐ ☐ Aspirin
☐ ☐ Arthritis	☐ ☐ Frequent Ear Infections	☐ ☐ Codeine
☐ ☐ Anemia	☐ ☐ Frequent Headaches	☐ ☐ Dental Anesthetics
☐ ☐ Blood Transfusion	☐ ☐ High Blood Pressure	☐ ☐ Erythromycin
☐ ☐ Hepatitis Type ___	☐ ☐ Low Blood Pressure	☐ ☐ Jewelry
☐ ☐ Hemophilia	☐ ☐ Immunologic Concerns	☐ ☐ Latex
☐ ☐ HIV & AIDS	☐ ☐ Kidney Problems	☐ ☐ Metals
☐ ☐ Bruise Easily	☐ ☐ Liver Disease	☐ ☐ Penicillin

☐ ☐ Cancer – Chemotherapy ☐ ☐ Cerebral Palsy ☐ ☐ Spina Bifida ☐ ☐ Colitis ☐ ☐ Diabetes ☐ ☐ Difficulty Breathing	☐ ☐ Measles/Mumps/Chicken Pox ☐ ☐ Rheumatic/Scarlet Fever ☐ ☐ Radiation Therapy ☐ ☐ Reflux / Vomiting ☐ ☐ Seizures Or Epilepsy ☐ ☐ Sickle Cell Disease	☐ ☐ Tetracycline Other ___________________________ ___________________________

Medications:

____
____
____

Y N
☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below:

____
____
____
____
____

Name of person completing this form ____

____ ________________________
Signature Date

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