

Westbrook Dental Centre Child-Medical History

Please complete the following medical and dental questions as accurately as possible. This is essential in order for the dentist to provide safe and optimal dental care.

Patient Name: Medical Alert:

Date:

1. When did your child last visit the physician?

Reason:

2. Has your child ever had any serious illness or been in the hospital?..... Yes No

Specify:

3. Does your child have any known medical, physical or mental disabilities?..... Yes No

Specify:

4. Has your child ever had any of the following?:

- | | | | |
|-------------------------|-----------------|---------------------|--|
| Measles | Asthma | Shortness of breath | Kidney Disease |
| Mumps | Hay Fever | Lung Disease | Diabetes |
| Chicken Pox | Heart Trouble | Tuberculosis | Gland Trouble |
| Scarlet Fever | Rheumatic Fever | Nervous Disorder | Broken Bones |
| Strep. Throat | Chest Pains | Epilepsy | Operations |
| Tonsilectomy | Fainting Spells | Liver Disease | Ear Trouble |
| Adenoid Trouble | Ankle Swelling | Jaundice | HIV Positive |
| Abnormal Blood Pressure | AIDS | Other | <input style="width: 150px;" type="text"/> |

If "Yes" to any of the above, please specify:

5. Has your child ever had any of the following?:

- | | | |
|-------------------|---------------------|-----------|
| Penicillin | Other Antibiotics | Cortisone |
| Local Anaesthesia | General Anaesthesia | |

6. Is your child taking any medication now?..... Yes No

Drug: Reason:

Drug: Reason:

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7. Has your child ever had a negative reaction to any drug?..... Yes No

Specify:

8. Is your child allergic to anything?..... Yes No

Specify:

9. Has your child ever has rheumatic fever?..... Yes No

10. Have you ever been advised that your child needs to take antibiotics before dental treatment?..... Yes No

11. Does your child have any blood disease?..... Yes No

Specify:

12. Does your child have any emotional problems?..... Yes No

13. Is there a history of any inherited diseases in the family?..... Yes No

Specify: