



Family & Cosmetic Dentistry

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CHILD'S MEDICAL HISTORY

Child's Name: _____ Age: _____ Parent/Guardian: _____

Child's Physician and their specialty: _____ Phone Number: _____

Most Recent examination: _____ Purpose: _____

What is your child's general health? Excellent Good Fair Poor

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING? YES NO

- | | | |
|---|--------------------------|--------------------------|
| 1. Is the Child currently under the care of a physician | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes describe: _____ | | |
| 2. Abnormal bleeding _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Anemia _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Blood Transfusion _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Cancer/Chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chicken Pox _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Congenital Heart Defect _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Diabetes _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Difficulty Breathing _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Epilepsy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Fainting Spells _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Frequent Headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Hay Fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Hearing Impaired _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Heart Murmur _____ | <input type="checkbox"/> | <input type="checkbox"/> |

YES NO

- | | | |
|---------------------------------|--------------------------|--------------------------|
| 17. Heart Surgery _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Hemophilia _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Hepatitis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Herpes/Fever Blisters _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. HIV+ / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Hospital Stay _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Joint Replacement _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Kidney Problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Learning Disabilities _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Liver Disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Mitral Valve Prolapse _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Operations _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Psychiatric Problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Radiation Treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Rheumatic Fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Seizures _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Sickle Cell Disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Please list any other medical conditions that the child has ever had: _____

Is the child allergic to any of the following?

- | | | |
|-------------------------|--------------------------|--------------------------|
| | YES | No |
| Aspirin _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental Anesthetic _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--------------------|--------------------------|--------------------------|
| | Yes | No |
| Erythromycin _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--------------------|--------------------------|--------------------------|
| | Yes | No |
| Tetracycline _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

If Other please explain: _____

Please list all prescriptions / over-the-counter medications that the child is currently taking: _____

Please list any other medications/food that the child is allergic to: _____

Anything you would like to discuss with the Doctor in private? Yes No

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN THE CHILD'S MEDICAL HISTORY OR ANY MEDICATIONS THE CHILD MAY BE TAKING.

I understand the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

Parent/Guardian Signature: _____ Date: _____