ISLANDS PEDIATRIC DENTISTRY

A MEMBER OF CHOICE HEALTHCARE SERVICES

MEDICAL HISTORY UPDATE

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Has your child recently been diagnosed with any of the following? (No changes – please mark 'None')

- ☐ Cancer or Tumor
- ☐ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ☐ Rheumatic Fever
- ☐ High / Low Blood Pressure
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Fractured jaw
- ☐ Anemia or blood disorders
- ☐ Hay Fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Autism
- ☐ ADHD / ADD
- ☐ Premature Birth
- ☐ Hearing Problems
- ☐ Intellectual Disability
- ☐ Congenital Birth Defects
- ☐ Speech Problems
- ☐ Behavioral Problems
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Autoimmune System Problems
- ☐ Tuberculosis or other lung problems
- ☐ Kidney Disease
- ☐ Hepatitis or other liver disease
- ☐ Blood Transfusions; Date of last transfusion _____
- ☐ Diabetes
- ☐ Epilepsy, seizures, or fainting spells
- ☐ COVID-19; Date of positive test result _____
- ☐ Other: _____
- ☐ NONE

For those conditions marked, please explain:

Does your child require an antibiotic before dental treatment? **Yes** **No**

If yes, please note antibiotic _____

Preferred Pharmacy/Cross Streets _____ Phone _____

Is your child currently taking any medication(s)? **Yes** **No**

If yes, please list medication(s) _____

Is your child allergic to, or has your child reacted adversely to any of the following?

- ☐ Latex
- ☐ Penicillin or Other Antibiotics
- ☐ Local Anesthesia
- ☐ Codeine or Other Drugs
- ☐ Aspirin
- ☐ Other: _____
- ☐ NONE

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur, I will notify the office and update my file.

Signature _____ **Date** _____