DATE _____

Child's Name _____ Sex _____ Birth date _____ Place of Birth_____
Last, First (Nickname)
Date of last medical examination _____ Child's Physician/Pediatrician _____

Physician's Address /Phone Number _____

MEDICAL HISTORY

GROWTH AND DEVELOPMENT	Any learning, behavioral, excessive nervousness, or communication problems?	No ( ) Yes ( )
	Has child had psychological counseling or is counseling being considered for the near future?	No ( ) Yes ( )
	Were there any complications during pregnancy or was child premature at birth?	No ( ) Yes ( )
	Any problems with physical growth?	No ( ) Yes ( )
CENTRAL NERVOUS SYSTEM	Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	No ( ) Yes ( )
	Any history of injury to the head?	No ( ) Yes ( )
	Any sensory disorders? (Seeing, Hearing)	No ( ) Yes ( )
CARDIOVASCULAR SYSTEM	Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever?	No ( ) Yes ( )
	Has any heart surgery been done or recommended?	No ( ) Yes ( )
	Any history of chest pains or high blood pressure?	No ( ) Yes ( )
HEMATOPOIETIC AND LYMPHATIC SYSTEMS	Has your child ever had a blood transfusion or blood products transfusion?	No ( ) Yes ( )
	Any history of anemia or sickle cell disease?	No ( ) Yes ( )
	Does your child bruise easily, have frequent nosebleed, or bleed excessively from small cuts?	No ( ) Yes ( )
	Is your child more susceptible to infections than other children are?	No ( ) Yes ( )
	Is there any history of tender or swollen lymph nodes or glands?	No ( ) Yes ( )
RESPIRATORY SYSTEM	Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing?	No ( ) Yes ( )
GASTROINTESTINAL SYSTEM	Any history of stomach, intestinal or liver problems?	No ( ) Yes ( )
	Any history of hepatitis or jaundice?	No ( ) Yes ( )
	Any history of eating disorders, such as anorexia nervosa or bulimia (binge/purge)?	No ( ) Yes ( )
	Any history of unintentional weight loss?	No ( ) Yes ( )
GENITOURINARY SYSTEM	Any history of urinary tract infections, bladder or kidney problems?	No ( ) Yes ( )
	Is the patient pregnant or possibly pregnant?	No ( ) Yes ( )
ENDOCRINE SYSTEM	Any history of diabetes?	No ( ) Yes ( )
	Any history of thyroid disorders or other glandular disorders?	No ( ) Yes ( )
SKIN	Any history of skin problems?	No ( ) Yes ( )
	Any history of cold sores (herpes) or canker sores (aphthae)?	No ( ) Yes ( )
EXTREMITIES	Any limitations of use of arms or legs?	No ( ) Yes ( )
	Any arthritis, joint bleeding, joint replacements or other joint problems?	No ( ) Yes ( )
	Any problems with muscle weakness or muscular dystrophy?	No ( ) Yes ( )
ALLERGIES	Is your child allergic to any medications? Name of drug(s)_____	No ( ) Yes ( )
	Any hay fever, hives, or skin rashes caused by allergies?	No ( ) Yes ( )
	Any other allergies?	No ( ) Yes ( )
MEDICATIONS OR TREATMENTS	Is your child currently taking any medication (prescription or non-prescription medicine) ?	No ( ) Yes ( )
	If yes, Medication (s) Dosage Time Per Day	
	_____ _____ _____	
	_____ _____ _____	
	_____ _____ _____	
	Has your child received radiation therapy (x-ray treatments) or is it planned?	No ( ) Yes ( )
	Has your child ever received chemotherapy or is it planned?	No ( ) Yes ( )
HOSPITALIZATIONS	Has your child been hospitalized?	No ( ) Yes ( )
	Hospital (1) _____ (2) _____ (3)_____	
	Date _____ _____ _____	
	Reason _____ _____ _____	
IMMUNIZATIONS	Is your child presently protected by immunization against DPT: Diphtheria, whooping Cough (pertussis), tetanus?	No ( ) Yes ( )
	OPV: Polio or poliomyelitis?	No ( ) Yes ( )
	MMR: Measles (rubeola), mumps, and German measles (rubella)?	No ( ) Yes ( )
	H influenzae type b or Hib?	No ( ) Yes ( )
	Hepatitis B or Hep B?	No ( ) Yes ( )

Varicella or Var (Chickenpox)? No ( ) Yes ( )

Please check any of the following that your child has now, has recently been exposed to, or has had in the past:

	NOW	EXPOSED	PAST
Chickenpox (varicella)	_____	_____	_____
Earache (otitis)	_____	_____	_____
Eye infection (conjunctivitis)	_____	_____	_____
German measles or 3-day measles (rubella)	_____	_____	_____
Glandular fever or mono (infectious mononucleosis)	_____	_____	_____
HIV/AIDS	_____	_____	_____
Lead poisoning	_____	_____	_____
Measles (rubeola)	_____	_____	_____
Mumps (parotitis)	_____	_____	_____
Scarlet fever (scarlatina)	_____	_____	_____
Sore throat (tonsillitis or pharyngitis)	_____	_____	_____
Substance abuse, alcoholism, drug addiction	_____	_____	_____
Tuberculosis	_____	_____	_____
Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, or tonsillitis)	_____	_____	_____
Venereal disease (genital herpes, gonorrhea, syphilis or other)	_____	_____	_____

DENTAL HISTORY

Does your child have a toothache or other immediate dental problem? No ( ) Yes ( )
Has your child ever had a toothache? No ( ) Yes ( )
Has your child had any injury to the mouth, teeth or jaws (fall, blow, etc.)? No ( ) Yes ( )
Is this your child's first dental visit? No ( ) Yes ( )
If no: Date _____ Dentist _____
Reason _____
Has your child ever had an unfavorable dental experience? No ( ) Yes ( )
What is your child's attitude to dentistry? _____
Is (was) your child nourished by nursing beyond one year of age? No ( ) Yes ( )
If yes, check: Breast _____ Nursing bottle _____ Both _____, and to what age? _____
Does your child fail to eat a well-balanced diet? No ( ) Yes ( )
If yes, what foods or food groups are not adequate? _____
Does (or has) your child have (or had) sucking habit beyond one year of age? No ( ) Yes ( )
If yes, check: Thumb(s) ____Finger(s) ____ Pacifier ____ Other _____
Does (or has) your child have (or had) any other oral habits beyond one year of age? No ( ) Yes ( )
If yes, check: Lip biting ____ Mouth breathing ____ Nail biting ____Teeth-grinding _____ Other _____
Does (or has) your child had (or had) difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in a certain position? No ( ) Yes ( )
Does (or has) your child have (or had) popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )
Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks? No ( ) Yes ( )

DENTAL DISEASE PREVENTION

How often does your child brush? _____ time(s) per _____
Does your child use dental floss? No ( ) Yes ( )
Does someone assist your child with brushing and cleaning the teeth? No ( ) Yes ( )
Does someone inspect for thoroughness after the procedure? No ( ) Yes ( )
Does your child use a fluoride toothpaste? No ( ) Yes ( )
Has your child ever had a fluoride treatment? No ( ) Yes ( )
Has your child ever taken a fluoride supplement or vitamins with fluoride? No ( ) Yes ( )
Drinking water source: City water supply _____ Name of city _____
Private well or other than city _____ Has a fluoride analysis been done? _____
Date of analysis _____ Fluoride content _____

_____ _____
Signature (parent or guardian) **Date**

DOCTOR'S COMMENTS **Medical consultation recommended? No _____ Yes _____**
Date requested _____
Purpose for consultation: _____

SEMI-ANNUAL REVIEW OF MEDICAL-DENTAL HISTORY

If history remains essentially unchanged, sign below.

Date _____ Parent _____ DR. _____ Remark _____
Date _____ Parent _____ DR. _____ Remark _____
Date _____ Parent _____ DR. _____ Remark _____