MEDICAL HISTORY QUESTIONNAIRE

These questions are of great value in helping me to better understand your child. Please complete each question on both sides of this form. All answers are kept CONFIDENTIAL. Utilize space at the end of the questionnaire to elaborate on any of these questions.

Child's Name ______________________________ Nickname, if any ____________________
(First) (Middle) (Last)

Age ____ Date of Birth ______________ Sex (F) __ (M) __ Place of Birth ____________________
(MM/DD/YYYY)

Attends What School ______________________________ Grade ____________________

Is your child in good health?………………………………………………………………….. Yes ___ No ___
Is your child now under the care of a physician?……………………………………………… Yes ___ No ___
If so, what is the condition being treated? ______________________________
Name of Pediatrician or Family Physician ______________________________
Address & Phone ______________________________
Date of last physical examination ______________________________
Has your child's physician or a cardiologist informed you of your child's need to be placed on prophylactic antibiotic therapy prior to his/her dental procedures?……………… Yes ___ No ___
Which drug? ______________________________
Did your child have trouble at birth or during the early years?……………………………….. Yes ___ No ___
Please describe ______________________________
Has your child had any serious illness or injury? Describe ____________________ Yes ___ No ___
Has your child ever been hospitalized? Describe ____________________ Yes ___ No ___
Does this child have any problems with recurrent headaches?……………………………… Yes ___ No ___
Medications/Dosage? ______________________________
Has this child had any history of Temporo-Mandibular Dysfunction?……………………….. Yes ___ No ___
If so, describe ______________________________
Does your child currently take any drug(s) or medicine?…………………………………… Yes ___ No ___
If so, what/how often? ______________________________
Have your child's tonsils or adenoids been removed?……………………………………….. Yes ___ No ___
If yes, when? ______________________________
Is this child physically or mentally handicapped?……………………………………………… Yes ___ No ___
If so, describe ______________________________
Does this child have a learning or behavior problem?………………………………………… Yes ___ No ___
If so, describe ______________________________

Has this child ever had any history of the following? If "YES," please check (√) below.

__ Immunization (Are they up to date?)
DPT Hepatitis Hemophilis Influenza
Measles German Measles Polio
__ Asthma
__ Lung Problems
__ Arthritis (Joint Pain or Swelling)
__ Jaundice (Yellow skin and eyes)
__ Blood Diseases
__ Diabetes
__ Tuberculosis
__ Scarlet Fever
__ Blood Transfusions Date(s) ________
__ HIV/Acquired Immune Deficiency Syndrome
__ Bone Disorders
__ Serious Head Injuries
__ Congenital Birth Defects

__ Any Heart Problems
__ Kidney Involvement
__ Liver/GI Involvement
__ Convulsions & Seizures
__ Epilepsy
__ Heart Murmur
__ Functional
__ Organic
__ Fever Blisters or Cold Sores
__ Bleeding Disorders
__ Anemia
__ Cleft Lip and/or Palate
__ Sickle Cell Anemia
__ Cancer, Tumors, Blood Dyscrasias
__ Endocrine System
__ Hepatitis
__ Cerebral Palsy

__ Measles
__ Hearing Problems
__ Speech Problems
__ Sight Problems
__ Severe Infections
__ Viral
__ Bacterial
__ Other
__ Other

Has this child ever experienced an unusual reaction (allergy or sensitization) to any of the following medicines? If YES, please check (√) below.

__ Aspirin
__ Penicillin
__ Sulfonamides (Sulfa)
__ Other Medicines (Remarks)
__ Ataraxics (Tranquilizers)
__ Dental Local Anesthetics (To put teeth to sleep)
__ Food
__ Pollen __ Dust __ Other

Comments (Explanations must be given for each (√) answer.)

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Additional Information: In the space below, please indicate any special concern or provide additional information which you think may be useful in providing dental care of your child.

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Parent or Guardian Signature: ______________________________

In case of emergency, contact: ______________________________

Relationship: ______________________ Phone: ______________

INSURANCE ASSIGNMENT of BENEFITS:
I authorize the attending dentist to release any information relating to this claim, and the insurance company to make payment of the dental benefits directly to the attending dentist.

I understand that I am financially responsible to the dentist for any charges not payable by the dental insurance program.

______________________ ______________________
Date Signature of Parent or Guardian

CONSENT FOR TREATMENT REGARDING: ______________________ (Name of Patient)

1. The undersigned hereby authorizes the doctors to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. In addition, I understand that using anesthetic/sedation agents embodies a certain risk.
3. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment. If any treatment should vary from that being contemplated, and if there is no reasonable opportunity for additional explanation and authorization, the parent or guardian further authorizes Dr. Block to proceed with such treatment she considers advisable based on her opinion and judgment.
4. In Pediatric Dentistry as in all other healthcare treatment, there can be no guarantees of particular outcomes. The anticipated benefits are based on results from treating similar conditions and may vary depending on patient cooperation, individual physical and psychological differences, and a number of other factors.

______________________ ______________ ______________
Parent or Guardian Date Witness