

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.

- | | | |
|--|---|--|
| <input type="checkbox"/> Immunization (Are they up to date?) | <input type="checkbox"/> Any Heart Problems | <input type="checkbox"/> Measles |
| <input type="checkbox"/> DPT | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver/GI Involvement | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Hemophilis | <input type="checkbox"/> Convulsions & Seizures | <input type="checkbox"/> Sight Problems |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Severe Infections |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> ___ Viral |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> ___ Functional | <input type="checkbox"/> ___ Bacterial |
| <input type="checkbox"/> Polio | <input type="checkbox"/> ___ Organic | <input type="checkbox"/> ___ Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever Blisters or Cold Sores | <input type="checkbox"/> Other |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Bleeding Disorders | |
| <input type="checkbox"/> Arthritis (Joint Pain or Swelling) | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Jaundice (Yellow skin and eyes) | <input type="checkbox"/> Cleft Lip and/or Palate | |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Sickle Cell Anemia | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer, Tumors, Blood Dyscrasias | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Endocrine System | |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Blood Transfusions Date(s) _____ | <input type="checkbox"/> Cerebral Palsy | |
| <input type="checkbox"/> HIV/Acquired Immune Deficiency Syndrome | | |
| <input type="checkbox"/> Bone Disorders | | |
| <input type="checkbox"/> Serious Head Injuries | | |
| <input type="checkbox"/> Congenital Birth Defects | | |

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

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ataraxics (Tranquilizers) |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Dental Local Anesthetics (To put teeth to sleep) |
| <input type="checkbox"/> Sulfonamides (Sulfa) | <input type="checkbox"/> Food |
| <input type="checkbox"/> Other Medicines (Remarks) | <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Other |

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

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.

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