Patient Name_____ Sex: M - F Birthdate _____

Patient's Physician_____ Date of Last Physical _____

## MEDICAL HISTORY

*** Please explain any "yes" answers**

ARE ANTIBIOTICS REQUIRED PRIOR TO DENTAL TREATMENT? .....No Yes explain:
Heart murmur, condition or disease? .....No Yes explain:
Rheumatic fever? .....No Yes
Arthritis, JRA or rheumatoid? .....No Yes
Hospital stays or operations? .....Please List
Rods, pins, plates or artificial joints? .....No Yes
Allergies to any medications, penicillins,
antibiotics or anesthetics? .....Please List
Allergies to gluten, foods, materials or tree nuts? .....No Yes
Any reaction to latex (balloons, rubber gloves, band-aids)? .....No Yes
Asthma, lung disease, inhalers or TB (tuberculosis)? .....No Yes
Ear infections or ear tubes (circle one)? .....No Yes
Blood diseases; anemias, hemophelia, leukemia? .....No Yes
Blood transfusions, AIDS or HIV testing? .....No Yes
Cerebral palsy, genetic syndromes or special needs .....No Yes
Convulsions, seizure disorders or epilepsy? .....No Yes
Liver disease, hepatitis or kidney disease? .....No Yes
Diabetes or insulin? .....No Yes
Eating disorder, bulimia, anorexia or reflux disease? .....No Yes
Cancer, tumors, growths or cysts? .....No Yes
Current medications or prescriptions and reason why? _____
_____
Learning, behavioral or emotional conditions? .....No Yes explain:
ADD, ADHD, Asperger's or autism .....No Yes
Any recent infections, MRSA? .....No Yes
Is the female patient pregnant or suspect they may be? .....No Yes
Is there anything else we should know about your child's health? _____
_____

## DENTAL HISTORY

*** Please explain any "yes" answers**

Is your child currently in pain, have a toothache or cavity? .....No Yes
Major injuries to the face or teeth? .....No Yes
Does your child wear a mouthguard for sports? .....No Yes
Major dental concerns or questions? .....Please List
Speech problems or speech therapy? .....No Yes
Thumb or finger habit, pacifier (nuk) habit? .....No Past Present
Grinding or clenching of teeth? .....No Yes
Tenderness in the jaw or joint (TMD/TMJ)? .....No Yes
Is your child's water fluoridated? .....No Yes
Does your child take a fluoride supplement daily? .....No Yes
How many times are the teeth brushed each day? _____
How many times are the teeth flossed each week? _____
Date of last dental exam/cleaning? _____
Have there been any unfavorable dental experiences? .....No Yes
How do you think your child will react to this dental visit? cooperative uncooperative not sure

Emergency contact other than parents_____ Phone _____

Parent/Guardian or Patient Signature_____ Date _____

Dr. Miller's Signature_____ Date _____