Medical History

Does the patient have any of the following medical issues? (Check any that apply)

__Allergies (See Below)
__ Asthma/Breathing Problems
__ ADD/ADHD
__ Autism Spectrum Disorder
__ Bleeding Problems
__ Disabilities: _____
__ Cancer
__ Down Syndrome
__ Diabetes/Endocrine Problems
__ Kidney/Liver Problems
__ Epilepsy/Seizures
__ Hospitalization:_____
__ High Blood Pressure
__ Psychiatric Problems
__ HIV/AIDS
__ Sinus Problems
__ Skin Conditions or Eczema
__ Speech/Hearing Concern

Does the patient have any of the following allergies? (Circle all that apply)

__ Anesthetic
__ Seasonal/Environmental
__ Latex
__ Penicillin
__ Pain Meds (Tylenol, Ibuprofen, Aspirin)
__ Sulfa Drugs
__ Other:_____
__ Other:_____

Please list any medications that the patient is currently taking: _____

_____

Has the patient had any surgeries? Please describe._____

_____

Are there any other medical conditions of which we should be aware?_____

_____

I hereby grant permission to the staff of this office for the administration of such anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The medical information as answered on this form is correct to the best of my knowledge.

Signature: _____Relationship: _____

Parent/guardian name: _____Date: _____