the kids dentist

Medical History

Do you have any of the following medical issues? (Circle 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

Do you 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 you are currently taking: _____

_____

Have you 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: _____ Date: _____

Patient name: _____ Date: _____