Medical Conditions / History

Name: ________________________ **Date of Birth:** __________

Please check Yes or No below:

Y	N		Y	N		Y	N	
☐	☐	ADHD	☐	☐	Headaches	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Shortness of Breath
☐	☐	Asthma	☐	☐	Jaundice	☐	☐	Sleep Apnea
☐	☐	Back/Neck Problems	☐	☐	Kidney Disease	☐	☐	Stomach Problems
☐	☐	Blood Disease	☐	☐	Liver Disease	☐	☐	Seasonal Allergies
☐	☐	Cancer (past or present)	☐	☐	Mental Conditions	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Nervous Disorders	☐	☐	Tonsillitis
☐	☐	Epilepsy	☐	☐	Radiation Therapy	☐	☐	Tumors
☐	☐	Excessive Bleeding	☐	☐	Reflux	☐	☐	Ulcers
☐	☐	Fainting	☐	☐	Respiratory Disease			

Other Medical Conditions not mentioned above:

Allergies (medications, latex, anesthetics, etc):

Current Medications and Vitamins:

Is your child up to date on their vaccinations?

___Yes ___No

Name of physician / pediatrician:

Has your child been hospitalized or needed emergency care in the past two years?

___Yes ___No Reason:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the dentist and hygienist at my next appointment.

Signature of parent/guardian *Date*