Pear Tree Dental Medical History - Child(NEW FORM)(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your child's mouth, the mouth is a part of the entire body.

Health problems your child may have, or medication your child may be taking, could have an important interrelationship with the dentistry

Thank you for answering the following questions.

Is your child under a physician's care now?	○ Yes ○ No	If yes
Has your child ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Is water in the home fluoridated?	○ Yes ○ No	
Does your child take fluoride supplements?	○ Yes ○ No	If yes
Is your child taking any medications, pills or herbs?	○ Yes ○ No	If yes

Does your child have any of the following habits?

☐ Lip Sucking / Biting ☐ Nail Biting ☐ Nursing Bottle Habits ☐ Thumb / Finger Sucking

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metals ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergy? ☐ If yes

Does your child have, or has ever had any of the following? If yes, please explain below.

Irregular Heartbeat	○ Yes ○ No	Stroke	○ Yes ○ No	Cold Sores / Fever Blisters	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Epilepsy / Seizures	○ Yes ○ No	AIDS / HIV Positive	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Fainting Spells / Dizziness	○ Yes ○ No	Autism Spectrum	○ Yes ○ No
Measles	○ Yes ○ No	Blood Disorders	○ Yes ○ No	ADD / ADHD	○ Yes ○ No
Hearing Problems	○ Yes ○ No	Liver Problems	○ Yes ○ No	Asthma	○ Yes ○ No
Hepatitis	○ Yes ○ No	Shortness of Breath	○ Yes ○ No	Anxiety	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Snoring / Obstructive Sleep Ap	○ Yes ○ No	Arthritis	○ Yes ○ No
Diabetes	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Cancer	○ Yes ○ No
Tonsillitis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Anaphylaxis	○ Yes ○ No

Has your child ever had any serious illness not	○ Yes ○ No	If yes
Is there anything else we should know about your child's health that we have not covered in this form?	○ Yes ○ No	If yes

To the best of my knowledge, the answers on this form are correct. I understand that providing incorrect information can be dangerous to

It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____