

MEDICAL HISTORY(child)

NAME:

Birth Date:

Has your child any history of or difficulty with any of the following?

Yes No

Latex Allergy
Cardiovascular Disease
Heart Murmur
Congenital Heart Lesions
Hyperactivity
ADHD
Autism Spectrum
Sensory Disorders

Yes No

HIV positive
Autoimmune Disorder
Kidney Trouble
Environmental Allergies
Food Allergies
Sinus Trouble
Asthma
Cancer

Yes No

Blood Disorder
Liver Disease
Neurologic Disorder
Seizures
Diabetes
Arthritis
Tuberculosis
Other

Was your child's birth premature? Yes ☐ No ☐ How early? _____

Has your child ever experienced excessive bleeding? Yes ☐ No ☐

If yes, please explain: _____

Has your child ever had surgery, radiation therapy, or been hospitalized? Yes ☐ No ☐

Purpose: _____

Does your child have any mental ☐ Emotional ☐ Physical ☐ limitations? _____

Is your child taking medications? Yes ☐ No ☐ If yes, what? _____

Does your child take fluoride in any form? Yes ☐ No ☐

Has your child ever experienced an allergic reaction to any medications or substances? Yes ☐ No ☐

If yes, what? _____

Name of Pediatrician/Physician _____

Location or Address: _____

Does your child have any medical condition not listed above? Yes ☐ No ☐

If yes, please explain: _____

Is this your child's first visit to any dentist? Yes ☐ No ☐ Date of last visit? _____

Does any of the following apply to your child?

- ☐ Injury to mouth or teeth
- ☐ Unhappy dental experiences
- ☐ Tooth ache
- ☐ Prolonged pacifier, thumb or finger sucking
- ☐ Currently bottle fed

- ☐ Mouth breather
- ☐ Ear Infections
- ☐ Unusual speech habits
- ☐ Previous orthodontia

Does your child have any current dental complaints Yes ☐ No ☐

If yes, what? _____

Previous Dentist: _____

Please mention any special needs or additional information that might improve our understanding of your child.

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for the comfort and well being of my child.

Date: _____ Signature of parent or guardian; _____ Doctor's initials: _____

Patrice Espinosa, D.D.S.