

# Confidential Medical & Dental History for a Minor Patient

Today's Date: \_\_\_\_\_

Patient Name (first, MI, last): \_\_\_\_\_ Date of birth: \_\_\_\_\_

## Medical History (Please circle Yes or No for each)

1. Physician's name: \_\_\_\_\_ Physician's phone: \_\_\_\_\_
2. Date of last medical examination? \_\_\_\_\_ Weight: \_\_\_\_\_
3. Patient is in good health? Yes / No If no, why? \_\_\_\_\_
4. Patient has regular medical exams? Yes / No
5. Patient is under the care of a physician at this time? Yes / No If yes, why? \_\_\_\_\_
6. Patient is up to date with immunizations? Yes / No
7. Patient is presently taking medications? Yes / No If yes, what and why? \_\_\_\_\_
8. Patient has allergies (medications, food, latex/rubber)? Yes / No If yes, what? \_\_\_\_\_
9. Patient has been hospitalized? Yes / No If yes, why and when? \_\_\_\_\_
10. Patient has had any operations? Yes / No If yes, why and when? \_\_\_\_\_
11. Patient has had general anesthesia? Yes / No
12. If yes, were there any complications? Yes / No If yes, please explain complications: \_\_\_\_\_

## Has the patient experienced, have or had any of the following? (Please circle Yes or No for each)

- |  |   |
|--|---|
| Yes / No Anemia  | Yes / No Heart defects                    |
| Yes / No Arthritis, rheumatism   | Yes / No Heart disease /defects / murmurs |
| Yes / No Artificial prosthesis, organs, joints, implants, shunts, valves | Yes / No Hepatitis                        |
| Yes / No Asthma  | Yes / No High blood pressure              |
| Yes / No Blood disorder  | Yes / No Jaundice                         |
| Yes / No Blurred vision  | Yes / No Joint pain or stiffness          |
| Yes / No Bone pain   | Yes / No Kidney or bladder disease        |
| Yes / No Canker or cold sores  | Yes / No Muscle pain, weakness            |
| Yes / No Chest pain, tightness, wheezing                                 | Yes / No Persistent cough or runny nose   |
| Yes / No Diabetes  | Yes / No Recent significant weight loss   |
| Yes / No Diarrhea or constipation  | Yes / No Rheumatic fever                  |
| Yes / No Ear infections  | Yes / No Seizures                         |
| Yes / No Eating disorders  | Yes / No Sexual transmitted disease       |
| Yes / No Excessive thirst  | Yes / No Shortness of breath              |
| Yes / No Eye disease   | Yes / No Skin disease                     |
| Yes / No Fainting spells   | Yes / No Spina bifida                     |
| Yes / No Family history of diabetes                                      | Yes / No Stomach problems or ulcers       |
| Yes / No Fever   | Yes / No Stroke                           |
| Yes / No Frequent urination  | Yes / No Thyroid disease                  |
| Yes / No Frequent vomiting   | Yes / No Transplants                      |
| Yes / No Headaches   | Yes / No Tuberculosis                     |
| Yes / No Hearing problems, ear pain                                      | Yes / No Tumors or cancer                 |
| Yes / No Heart attack  | Yes / No Urinary tract Infections         |

## This information will not be released unless specifically authorized by patient.

- |  |                     |
|--|---------------------|
| Yes / No Treatment for emotional, mental, or physical delays | Yes / No Anxiety    |
| Yes / No AIDS/HIV  | Yes / No Depression |

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No

14. If yes, explain: \_\_\_\_\_

15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

(dental history continued on next page)

