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MEDICAL/DENTAL HISTORY

(Please Print)

Today's date:

MEDICAL HISTORY

Patient's last name:	First:	Birth date: / /	
Is your child taking any medications:	❑ Yes ❑ No	If yes, what?:	
Allergies:	❑ Yes ❑ No	If yes, what?:	
Child's Physician:		Phone Number:	

Does Your Child currently have or has had any of the following?:

ADD/ADHD:	❑ Yes ❑ No	Diabetes:	❑ Yes ❑ No
Anemia/Blood Problems:	❑ Yes ❑ No	Ear/Hearing Difficulties:	❑ Yes ❑ No
Arthritis/Joint Problems:	❑ Yes ❑ No	Endocrine/Glandular Problems:	❑ Yes ❑ No
Asthma/Breathing Problems:	❑ Yes ❑ No	Eye/Vision Problems:	❑ Yes ❑ No
Autism Spectrum:	❑ Yes ❑ No	Heart Conditions/Defects:	❑ Yes ❑ No
Behavioral Disorders:	❑ Yes ❑ No	Hepatitis/Jaundice:	❑ Yes ❑ No
Bleeding Problems:	❑ Yes ❑ No	HIV/AIDS:	❑ Yes ❑ No
Bone/Muscular Problems:	❑ Yes ❑ No	Kidney/Liver/Organ Problems:	❑ Yes ❑ No
Brain Injury:	❑ Yes ❑ No	Rheumatic Fever:	❑ Yes ❑ No
Cancer/Tumors:	❑ Yes ❑ No	Seizures/Epilepsy/Fainting:	❑ Yes ❑ No
Cerebral Palsy:	❑ Yes ❑ No	Sensory Disorder:	❑ Yes ❑ No
Cleft Lip/Palate:	❑ Yes ❑ No	Sickle Cell or Trait:	❑ Yes ❑ No

Please list any other medical conditions, past or present, including hospitalizations:

DENTAL HISTORY

Current Dentist:	Address/Phone Number:	Reason for Today's Visit:
Date of Last Dental Exam:	Date of Last Dental Xrays:	Unfavorable Dental Experiences? If yes, Explain:

Times Per Day Child Brushes:	Please list any other dental conditions or concerns you might have:
Thumb/Finger Sucking: ❑ Yes ❑ No	
Tongue Thrusting: ❑ Yes ❑ No	
Mouth Breathing: ❑ Yes ❑ No	
Tooth Grinding/Clenching: ❑ Yes ❑ No	
TMJ/Jaw Pain: ❑ Yes ❑ No	
Bad Breath: ❑ Yes ❑ No	
Orthodontic Treatment: ❑ Yes ❑ No	
Bedtime/Nursing Bottle: ❑ Yes ❑ No	
Sensitivity to Cold/Hot/Sweets: ❑ Yes ❑ No	

The above information is true to the best of my knowledge. I certify that I have read and understand the above questions. I will not hold Wagner Pediatric Dentistry, LLC responsible for any omissions I have made in completing this form.

Patient/Guardian signature *Date*