SUMMIT
PEDIATRIC DENTISTRY

Summit Pediatric Dentistry

Medical History Form

Patient Name: _____

Birth Date: _____

Is your child under a physician's care now? __Yes __No If yes: _____

Has your child ever been hospitalized or had surgery in a hospital? __Yes __No If yes: _____

Has your child ever had a serious head or Neck injury? __Yes __No If yes: _____

Please list current medications: _____

Does your child require a pre-med for any reason? __Yes __No If yes, what for? _____

Does your child have, or has your child had any of the following?

Anaphylaxis	__Yes __No	Hepatitis B or C	__Yes __No	Epilepsy or Seizures	__Yes __No
Bruise Easily	__Yes __No	Hives or Rash	__Yes __No	Asthma	__Yes __No
Fainting Spells/Dizziness	__Yes __No	Kidney Problem	__Yes __No	Breathing Problems	__Yes __No
Excessive Bleeding	__Yes __No	Cancer	__Yes __No	Hay Fever	__Yes __No
Cold Sores/Fever Blister	__Yes __No	Heart Murmur	__Yes __No	Down Syndrome	__Yes __No
Psychiatric Care	__Yes __No	Diabetes	__Yes __No	Autism/Asperger's	__Yes __No
Hearing Loss	__Yes __No	Anxiety	__Yes __No	Developmental Delay	__Yes __No
Reflux/GI Issues	__Yes __No	ADD or ADHD	__Yes __No	Learning Disability	__Yes __No
Heart Trouble/Disease	__Yes __No	Snoring/Mouth Breathing	__Yes __No	Latex Allergy	__Yes __No

Has/Does your child ever had any serious illness, surgery or condition not listed above? __ Yes __No
If yes:_____

Please list ANY food or medication allergies below:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Printed Name Relationship

_____ _____
Signature Date