Patient Name:_____ Is your child currently taking any medications? Yes/No

Medication List: _____

Are there any specific questions or concerns that you would like to have addressed today? Yes/No

List: _____

Please check any of the following that apply to your child:

	Condition
	ADD/ADHD
	AIDS/HIV
	Allergies
	Anxiety
	Anemia
	Artificial Heart Valve
	Artificial Joints
	Asthma
	Autism- Mild Severe
	Behavioral Problems
	Birth Defects
	Blood Disease
	Brain Injury
	Bruise Easily
	Cancer type:
	Chemical Dependency
	Chemotherapy
	Chicken Pox
	Child Abuse
	Cleft Palate/Lip
	Cold Sore/Canker Sore
	Developmentally Delayed: Age level is
	Depression
	Diabetes
	Dizziness/Fainting
	Down Syndrome
	Earaches/Infection
	Eye Conditions
	Excessive Bleeding

	Condition
	Heart Condition
	Heart Murmur
	Hemophilia
	Hepatitis A B C
	High Blood Pressure
	Hospital Stay/Operation:
	Injury to Front Teeth
	Kidney Disease
	Liver Disease
	Low Blood Pressure
	Lupus
	Mentally Handicapped
	Metallic Implant, Shunts, Pins, Rods
	Mitral Valve Prolapse
	Mononucleosis
	Pacemaker
	Psychiatric Care
	Radiation Head Neck Other:
	Recreational Drugs
	Rheumatic Fever
	Rheumatism
	Scarlet Fever
	Seizures type:
	Sleep Apnea or Snoring
	Sore Throats
	Speech Impairment
	Stomach Problems
	Thyroid Disease
	Tuberculosis

	Hearing Impairment			Other:

If you answered yes to any of these questions, please explain: _____

_____

	Allergy
	Aspirin
	Codeine
	Erythromycin
	Latex
	Local Anesthetic
	Nitrous Oxide
	Penicillin
	Food
	Other

When was your child's last dental visit?_____ Previous Dentist _____

Has your child experience any unfavorable reactions from previous dental or medical care? _____

How often does your child brush?_____ Floss? _____ Is it supervised? Yes/No

Has your child had orthodontic treatment? Yes/No Phase 1 Phase 2 Orthodontist _____

Parent/Guardian Signature: _____ Date: _____

Team Member: _____