



### MEDICAL HISTORY UPDATE

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Has your child recently been diagnosed with any of the following?** (No changes – please mark ‘None’)

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer or Tumor                                   | <input type="checkbox"/> Congenital Birth Defects                           |
| <input type="checkbox"/> Heart Murmur, Mitral Valve Prolapse, Heart Defect | <input type="checkbox"/> Speech Problems                                    |
| <input type="checkbox"/> Rheumatic Fever                                   | <input type="checkbox"/> Behavioral Problems                                |
| <input type="checkbox"/> High / Low Blood Pressure                         | <input type="checkbox"/> Pregnancy  |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Radiation Treatment                                |
| <input type="checkbox"/> Herpes or cold sores                              | <input type="checkbox"/> Autoimmune System Problems                         |
| <input type="checkbox"/> AIDS or HIV positive                              | <input type="checkbox"/> Tuberculosis or other lung problems                |
| <input type="checkbox"/> Migraine headaches or frequent headaches          | <input type="checkbox"/> Kidney Disease                                     |
| <input type="checkbox"/> Fractured jaw                                     | <input type="checkbox"/> Hepatitis or other liver disease                   |
| <input type="checkbox"/> Anemia or blood disorders                         | <input type="checkbox"/> Blood Transfusions; Date of last transfusion _____ |
| <input type="checkbox"/> Hay Fever or sinus trouble                        | <input type="checkbox"/> Diabetes   |
| <input type="checkbox"/> Allergies or hives                                | <input type="checkbox"/> Epilepsy, seizures, or fainting spells             |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> COVID-19; Date of positive test result _____       |
| <input type="checkbox"/> Autism  | <input type="checkbox"/> Other: _____                                       |
| <input type="checkbox"/> ADHD / ADD  | <input type="checkbox"/> NONE   |
| <input type="checkbox"/> Premature Birth                                   |   |
| <input type="checkbox"/> Hearing Problems                                  |   |
| <input type="checkbox"/> Intellectual Disability                           |   |

**For those conditions marked, please explain:**

**Does your child require an antibiotic before dental treatment?**      **Yes**      **No**

If yes, please note antibiotic \_\_\_\_\_

Preferred Pharmacy/Cross Streets \_\_\_\_\_ Phone \_\_\_\_\_

**Is your child currently taking any medication(s)?**      **Yes**      **No**

If yes, please list medication(s) \_\_\_\_\_

**Is your child allergic to, or has your child reacted adversely to any of the following?**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Latex                           | <input type="checkbox"/> Aspirin      |
| <input type="checkbox"/> Penicillin or Other Antibiotics | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Local Anesthesia                | <input type="checkbox"/> NONE         |
| <input type="checkbox"/> Codeine or Other Drugs          |                                       |

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur, I will notify the office and update my file.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_