PEDIATRIC DENTISTRY
BUTLER

Child's Name _____ Nickname _____ Birth date_____
Parent's Name_____ Home phone _____ Work phone _____Cell_____
Mailing address _____ City _____State _____ Zip _____
Whom may we thank for referring you to our office? _____

MEDICAL HEALTH HISTORY

Does your child have or has had any of the following?
Y N (Please check any that apply)

- ❑ ❑ Abnormal Bleeding
- ❑ ❑ AIDS/HIV
- ❑ ❑ Allergies
- ❑ ❑ Anemia
- ❑ ❑ Any Hospital Stays
- ❑ ❑ Any Operations
- ❑ ❑ Asthma
- ❑ ❑ Blood Dyscrasia
- ❑ ❑ Blood Transfusion
- ❑ ❑ Breathing / Lung Problems
- ❑ ❑ Cancer / Tumors
- ❑ ❑ Chicken Pox
- ❑ ❑ Congenital Birth Defect
- ❑ ❑ Congenital Heart Defect
- ❑ ❑ Diabetes
- ❑ ❑ Endocrine System Disorders
- ❑ ❑ Epilepsy
- ❑ ❑ Frequent Infections
- ❑ ❑ Handicaps
- ❑ ❑ Behavior / Learning
- ❑ ❑ Mentally/Physically Disabled
- ❑ ❑ Hearing Impaired
- ❑ ❑ Heart Murmur
- ❑ ❑ Hemophilia
- ❑ ❑ Hepatitis
- ❑ ❑ High Blood Pressure
- ❑ ❑ Hives
- ❑ ❑ Kidney Problems
- ❑ ❑ Liver/GI System Problems
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Lupus
- ❑ ❑ Measles
- ❑ ❑ Mitral Valve Prolapse
- ❑ ❑ Mononucleosis
- ❑ ❑ Recurrent / Frequent Headaches
- ❑ ❑ Rhematic
- ❑ ❑ Seizures
- ❑ ❑ Scarlet Fever
- ❑ ❑ Sickle Cell Anemia
- ❑ ❑ Sight Disorders
- ❑ ❑ Significant Injuries
- ❑ ❑ Skin Rash
- ❑ ❑ Tonsilitis
- ❑ ❑ Tuberculosis (TB)

Please list all medications and dosages that your child is currently taking:_____
_____

Are Immunizations Current? ❑ Yes ❑ No

Please describe your child's current physical health:
❑ Good ❑ Fair ❑ Poor

Does your child have social / personality/ temperament concerns that we should be aware of?
_____

Please list all drugs and/or things that cause your child allergic reaction:_____
_____

Name of your Pediatrician:_____Phone: _____
Does your child have any disease, condition, or problem not listed above?_____
_____
Please add anything else you would like us to know about: _____
_____

Signature of patient (or parent) _____ Date _____
Doctor's Signature _____ Date _____