

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

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** _____