MEDICAL HISTORY

Physician_____ Physician's Phone_____

Physician's Address_____

Date of last physical exam_____

YES	NO	
( )	( )	1. Is the child fearful of dentist visits?
( )	( )	2. Are teeth sensitive to anything, if so what?_____
( )	( )	3. Does the child have a history of: thumb sucking, tongue thrust, nail biting, mouth breathing, biting hard objects or hard swallowing? If yes - circle which are applicable.
( )	( )	4. Has the child had oral hygiene instruction?
( )	( )	5. Is the child under the care of a physician at this time? If so, for what conditions? _____
		_____
		6. Has the child had:
( )	( )	Allergies to medications? If so, please list_____
( )	( )	Anemia?
( )	( )	Asthma?
( )	( )	Circulatory problems?
( )	( )	Diabetes?
( )	( )	Epilepsy?
( )	( )	Heart problems? If so explain _____
( )	( )	High Blood Pressure?
( )	( )	Immunosuppressive disorder?
( )	( )	Kidney Disease?
( )	( )	Liver disease or hepatitis?
( )	( )	Mastoid/ear infection?
( )	( )	Nervous Problems?
( )	( )	Prolonged bleeding following injury or surgery?
( )	( )	Radiation Treatment?
( )	( )	Respiratory disease?
( )	( )	Rheumatic fever?
( )	( )	Tumors or growths?
( )	( )	Is the child now regularly taking over the counter and/or prescription medications? If so, please list:
		_____
		_____
( )	( )	Is there anything of importance in your medical history that has not been asked? If so, please explain:
		_____
		_____

Child's weight_____

The above information is accurate and complete to the best of my knowledge. I will not hold Longbranch Dental Center or any of its employees responsible for any errors or omissions that I may have made in the completion of this form.

Date_____**Signature**_____