



Medical & Dental History

**Has your child had any of the following medical or dental conditions or problems?
Please mark the appropriate answers below, and fill in the blanks where appropriate.**

Medical History

- Yes No Heart murmur
 - Yes No Heart problems
 - Yes No Rheumatic fever
 - Yes No Bleeding problems
 - Yes No Hemophilia
 - Yes No Asthma
 - Yes No Allergy to any drugs
 - Yes No Allergy to latex or plastic
 - Yes No Genetic disorders
 - Yes No Disabilities/Handicaps
 - Yes No Hearing problems
 - Yes No Vision problems
 - Yes No Cancer
 - Yes No Diabetes
 - Yes No HIV/AIDS
 - Yes No Tuberculosis
 - Yes No Hepatitis
 - Yes No Kidney or liver problems
 - Yes No Epilepsy or convulsions
 - Yes No Bone/Joint problems
 - Yes No Hospitalizations
 - Yes No Surgeries
 - Yes No Other medical problems or conditions (please explain)
- _____
- _____
- _____
-
- Yes No Current medications (please list)
- _____
- _____
- _____

Dental History

- Yes No Injuries to jaws or teeth
 - Yes No Toothaches
 - Yes No Abscesses (gum boils)
 - Yes No Frequent mouth sores
 - Yes No Bleeding gums
 - Yes No Thumb/Finger sucking habits
 - Yes No Lip Tongue biting habit
 - Yes No Clenching or grinding habit
 - Yes No Fluoridated water
 - Yes No Fluoride rinses/Supplements
 - Yes No Teeth brushed daily
 - Yes No Teeth flossed daily
 - Yes No First visit to dentist (if no, date of last visit)
- _____
- Yes No Problems associated with previous dental work (please explain)
- _____
- _____
- _____
- Yes No Other dental problems or conditions (please specify)
- _____
- _____
- _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and that it is my responsibility to inform Dr. Haring's office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date signed _____

Office Use Only — Medical history review and update

I have reviewed the medical and dental information above with the parent/guardian and patient named herein.

Date _____	Signature _____	Date _____	Signature _____
Date _____	Signature _____	Date _____	Signature _____
Date _____	Signature _____	Date _____	Signature _____
Date _____	Signature _____	Date _____	Signature _____
Date _____	Signature _____	Date _____	Signature _____