Patient Name: DOB:

Updated Medical / Dental History

Medical History

ADD/ADHD □ Yes □ No
Autism Spectrum Disorder □ Yes □ No
Sensory Issues □ Yes □ No

Allergy to foods □ Yes □ No
If Yes, List: _____
Allergy to medications □ Yes □ No
If Yes, List: _____

Allergy to latex □ Yes □ No
Anxiety □ Yes □ No
Asthma □ Yes □ No
Bleeding disorder □ Yes □ No
Bone/Joint problems □ Yes □ No
Cancer □ Yes □ No
Depression □ Yes □ No
Diabetes □ Yes □ No
Disabilities □ Yes □ No
If Yes, Explain: _____

Down syndrome □ Yes □ No

Eating Disorder □ Yes □ No
Please Specify: _____

Epilepsy/Convulsions □ Yes □ No
Genetic disorders □ Yes □ No
If Yes, Explain: _____

Hepatitis □ Yes □ No
Heart murmur □ Yes □ No
Heart Problems □ Yes □ No
If Yes, List: _____

Premedication for dental work □ Yes □ No
Hearing problems □ Yes □ No
If Yes, Explain: _____

Hemophilia □ Yes □ No
HIV/AIDS □ Yes □ No
Hospitalizations □ Yes □ No
If Yes, Explain: _____

Surgeries □ Yes □ No
If Yes, Explain: _____

Kidney/Liver Problems □ Yes □ No
Rheumatic Fever □ Yes □ No
Tuberculosis □ Yes □ No
Vision Problems □ Yes □ No
Glasses____ Contacts____
Other_____

If you answered yes to any of these questions, please provide additional information here:

Other medical problems or conditions (specify)

Dental History

Abscess (gum boils) □ Yes □ No
Bleeding gums □ Yes □ No
Clenching or grinding habit □ Yes □ No
Frequent mouth sores □ Yes □ No
Injuries to jaw or teeth □ Yes □ No
Toothaches □ Yes □ No

If you answered yes to any of these questions, please provide additional information here:

Daily flossing □ Yes □ No
Daily tooth brushing □ Yes □ No
Fluoridated water □ Yes □ No
Fluoride rinses/Supplements □ Yes □ No
Lip/tongue biting habit □ Yes □ No
Thumb/finger sucking habit □ Yes □ No

Current Medications (list)

I understand that the information that I have given is correct to the best of my knowledge and that is it my responsibility to inform Delaware Pediatric Dentistry of any changes in my child's medical status. I authorize the staff at Delaware Pediatric Dentistry to perform the necessary dental services my child may need.

Name of Parent or Guardian

Signature of Parent or Guardian

Relationship to Patient

Date

FOR OFFICE USE ONLY

I have reviewed the medical/dental information with the parent/legal guardian. Initials_____ Date_____

Doctor's Comments