**Dental/Medical History**

 Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Circle one)* Male / Female

1. Does your child have an unusual history of the following *(Please circle all that apply)*

 **Nursing/Bottle Habits Pacifier Thumb/Finger Sucking Dental Grinding**

1. Name of Child’s Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is Child taking any medications? Yes No *(If yes, please list medications)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is Child allergic to any of the following medications or substances? *(Please circle all that apply)*

**None** **Aspirin** **Penicillin** **Latex** **Foods Metal/Acrylics Other**

If Other, Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  **Please Check (Y) or (N)** | **Y** | **N** |  **Please Check (Y) or (N)** | **Y** | **N** |  **Please Check (Y) or (N)** | **Y** | **N** |
| ADHD |   |   | Chronic Adenoid/Tonsil Problem |   |   | Measles |   |   |
| AIDS/HIV Infection |   |   | Cleft Lip/Palate |   |   | Mental Health Problems |   |   |
| Alcohol/Drug Abuse |   |   | Developmentally Delayed |   |   | Mononucleosis |   |   |
| Allergies (Food) |   |   | Diabetes |   |   | Mumps |   |   |
| Allergies (Latex) |   |   | Diet Pills/Aids (Phen-Fen) |   |   | Neurological Disorders |   |   |
| Allergies (Medication) |   |   | Disabilities/Special Needs |   |   | Orthopedic Problems |   |   |
| Allergies (Seasonal) |   |   | Downs Syndrome |   |   | Osteoporosis |   |   |
| Anemia |   |   | Ears/Nose/Throat Issues |   |   | Pregnant |   |   |
| Anorexia |   |   | Emotional Disturbance |   |   | Premature Birth |   |   |
| Anxiety |   |   | Epilepsy/Seizures |   |   | Pre-Medicate Required |   |   |
| Arthritis |   |   | Excessive Gagging |   |   | Prosthetic Joints/Plates/Pin |   |   |
| Asthma/Breathing Problems |   |   | Fainting/Dizziness |   |   | Psychiatric Care |   |   |
| Autism |   |   | Fever Blisters |   |   | Rheumatic Heart Disease |   |   |
| Autoimmune Disease |   |   | Frequent Dry Mouth/Sjogren |   |   | Seizures |   |   |
| Birth Defects |   |   | GERD |   |   | Sickle Cell Anemia |   |   |
| Bladder Conditions |   |   | Growth Problems |   |   | Sinus Problems |   |   |
| Bleeding/Clotting Problems |   |   | Hearing Problems |   |   | Speech/Hearing Problems |   |   |
| Blood Transfusion |   |   | Heart Disease |   |   | Stroke |   |   |
| Brain Injury |   |   | Heart Murmur |   |   | Thyroid Problems |   |   |
| Bruise Easily |   |   | Hemophilia A |   |   | Tobacco Use |   |   |
| Cancer/Tumor or Growth |   |   | Hepatitis/Liver Disease |   |   | Tuberculosis |   |   |
| Cerebral Palsy |   |   | High Blood Pressure |   |   | Ulcers |   |   |
| Child Abuse |   |   | Kidney Disease |   |   | Vision Problems |   |   |
| Chemotherapy/Radiation |   |   | Leukemia |   |   | Other items not listed above |   |   |
| Chicken Pox/Shingles |   |   | Lung Disease |   |   |   |   |   |

If answered **‘’YES’’** to any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Dr’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

**Historial dental/médico**

 Nombre del niño:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dob:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Círculo uno)* Masculino / Femenino

1. ¿Tiene su hijo un historial inusual de lo siguiente *(Por favor, circule todos los que correspondan)*

**Enfermería/Hábitos de botella Chupete Chupadeo de pulgar/dedo Molienda dental**

1. Nombre del Médico del Niño:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Número de teléfono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. ¿El niño está tomando algún medicamento? Sí No *(En caso afirmativo, indique* los medicamentos)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ¿Es Child alérgico a alguno de los siguientes medicamentos o sustancias? *(Por favor, circule todos los que correspondan)*

**Ninguno Aspirina Penicilina Látex Alimentos Metal/Acrílicos Otro**

Si es otro, por favor enumere: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Comprobación (Y) o (N)** | **Y** | **N** | **Comprobación (Y) o (N)** | **Y** | **N** | **Comprobación (Y) o (N)** | **Y** | **N** |
| Desorden deficit hiperactivo |   |   | Paladar/Paladar Celft |   |   | Leucemia |   |   |
| SIDA / VIH |   |   | Retraso en el desarrollo |   |   | Enfermedad pulmonar |   |   |
| Abuso de alcohol/drogas |   |   | Diabetes |   |   | Sarampión |   |   |
| Alergias Al Latex |   |   | Dieta píldoras/SIDA |   |   | Problemas de salud mental |   |   |
| Alergias (estacional) |   |   | Necesidades especiales |   |   | Mononucleosis |   |   |
| Alergias (Medicación) |   |   | Sindrome de Down |   |   | Paperas |   |   |
| Anorexia |   |   | Oídos/Nariz/Garganta |   |   | Desórdenes neurológicos |   |   |
| Artritis |   |   | Disturbios emocionales |   |   | Problemas ortopédicos |   |   |
| Asma/problemas de respiración |   |   | Epilepsia/convulsiones |   |   | Osteoporosis |   |   |
| Autismo |   |   | Arcadas excesivas |   |   | Embarazada |   |   |
| Sangrado/coagulación |   |   | Desmayos/mareos |   |   |  |  |   |
| Transfusión de sangre |   |   | Ampollas de fiebre |   |   |  |  |   |
| Daño cerebral |   |   | Boca seca frecuente |   |   |  |  |   |
| Fácilmente abollado |   |   | Problemas de crecimiento |   |   |  |  |   |
| Cáncer/Tumor/Crecimiento |   |   | Escuchando problemas |   |   |  |  |   |
| Parálisis cerebral |   |   | Enfermedad del corazón |   |   |  |  |   |
| Abuso infantil |   |   | Soplo cardíaco |   |   |  |  |   |
| Quimioterapia/Radiación |   |   | Hepatitis/Enfermedad Hepática |   |   |  |  |   |
| Varicela/culebrilla |   |   | Alta presion sanguinea |   |   |  |  |   |
| Adenoides/Amígdalas Crónicas |   |   | Enfermedad del riñon |   |   |   |   |   |

Si se le responde **''SI''** a cualquiera de los anteriores, por favor explique:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma del Padre/Tutor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_ Fecha:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Firma del Dr.

Dr’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_