**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: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_