Medical History Update

Patient Name: _____ **DOB:** _____

Address: _____

Cell Phone: _____ **Home Phone:** _____ **Email:** _____

	YES	NO
Is your child being treated by a physician at this time?.....	☐	☐
Reason: _____		
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	☐	☐
List name and dose:		
Has your child had any hospitalizations, surgeries, injuries or allergic reactions since last visit?.....	☐	☐
Describe: _____		
Has your child ever had a reaction to or problem with an anesthetic?	☐	☐
Has your child ever had a reaction or allergy to an antibiotic, sedative, latex, or anything else?.....	☐	☐
List: _____		
Have there recently been any significant chages to your child's family, home or school routines?.....	☐	☐
Describe: _____		
Do you have any concerns with your child's teeth today (tooth pain, injury, cavity, etc.)?.....	☐	☐
Describe: _____		

Signature of Parent/Guardian Date:

Relationship to child: _____