EXPEDITION
PEDIATRIC DENTISTRY

Pediatric Medical History

Name of Child: _____ Date of Birth: _____ Gender: M/F

Child's Physician: _____ Physician Phone: _____
Date/Reason for last visit to Physician: _____
Are vaccinations current? ☐ Yes ☐ No Is your child in good health? ☐ Yes ☐ No
Has your child ever had a health problem? ☐ Yes ☐ No
If yes, explain: _____

Allergies/Adverse drug reactions: ☐ Yes ☐ No
If yes, explain: _____
Does your child have an allergy to latex, metals, acrylic, or dye? ☐ Yes ☐ No
If yes, explain: _____

Please list any medication(s) (prescription or over the counter), vitamins, or dietary supplements you child is currently taking.
List name, dose, and frequency: _____
_____
Does your child have any special needs? ☐ Yes ☐ No
If yes, please explain: _____
Has your child ever been hospitalized, had surgery, or had an emergency room visit? ☐ Yes ☐ No
If yes, list date and describe: _____
Has your child ever had sedation or general anesthesia? ☐ Yes ☐ No
If yes, explain: _____

Has your child ever had problems with or been treated by a doctor for any of the following? Please check all that apply and provide details below:

☐ Heart/Heart Murmur	☐ Adverse Drug Reaction	☐ Autism	☐ Hydrocephaly/Shunt
☐ Artificial Valve/Joint	☐ Bleeding/Hemophilia	☐ ADD/ADHD	☐ Abuse
☐ Heart Surgery	☐ Blood Transfusions	☐ Down Syndrome	☐ Thyroid/Pituitary
☐ Rheumatic Fever	☐ Anemia	☐ Genetic Abnormality	☐ MRSA
☐ Birth Defect	☐ Diabetes/Endocrine	☐ Mentally Challenged	☐ Sickle Cell Disease/Trait
☐ Seizures/Epilepsy	☐ Hepatitis	☐ Hives/Rash	☐ Sleep Apnea/Snoring
☐ High Blood Pressure	☐ AIDS or HIV+	☐ Cold Sores/Fever Blisters	☐ Learning Delays
☐ Irregular Heart Beat	☐ TB/Lung Disease	☐ Drug/Alcohol Addiction	☐ Behavioral Issues
☐ Cancer/Tumors	☐ Liver/GI Disease	☐ Nosebleeds	☐ Mental Disorder
☐ Headaches	☐ Asthma/Reactive Airway	☐ Eye/Visual Impairment	☐ Exposure to Tobacco
☐ Arthritis	☐ Skin/Eczema	☐ Speech/Hearing	☐ Kidney Disease
☐ Cerebral Palsy	☐ Cleft Lip/Palate	☐ Failure to Thrive	☐ Eating Disorder
☐ Muscle/Joint Problems	☐ Pregnancy	☐ Born Prematurely	☐ Cystic Fibrosis
☐ Limited Mobility	☐ Tonsil/Adenoids	☐ Syndrome (specify)	☐ GERD/Acid Reflux

☐ **Please review the above items carefully. Check here if *none* of the above conditions apply to your child.**

Please provide details here for items checked above: _____
_____
_____

I understand that the information that I have given is correct and accurate to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's dental and medical status.

Signature of Parent/Legal Guardian: _____Date: _____

Printed Name:_____ Relationship to Patient:_____