Child Medical History

Patient Name:____

Welcome to Anderson Dental Group! We're excited to provide your child with the best possible care!
Please know that all medical history provided will be kept completely confidential.

What is the reason for your visit today?____

Date of your child's last dental visit:___________________

Is your child currently under a physician's care? ☐ Yes ☐ No ______________________________________

Is your child currently taking any medications, pills, or drugs? ☐ Yes ☐ No List all medications:________________

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Are your child's immunizations current? ☐ Yes ☐ No ____

Is your child allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts	☐ Corn	☐ Dairy	☐ Soy

Other allergies not listed? ☐ Yes ☐ No ____

Does your child have any allergic or adverse reactions to any medication or any other substance not listed above?
☐ Yes ☐ No ____

Indicate which of the conditions your child currently has or has ever had:

☐ AIDS/HIV positive	☐ Allergies/Hives	☐ Anemia
☐ Asthma	☐ Behavioral/Learning Problems	☐ Bleeding Disorder
☐ Brain Injury/Concussions	☐ Cancer	☐ Cerebral Palsy
☐ Chicken Pox	☐ Congenital Heart Condition	☐ Diabetes
☐ Epilepsy/Seizures	☐ Handicap/Disability	☐ Hay Fever
☐ Hearing Problem	☐ Heart Condition	☐ Hepatitis A, B, or C
☐ Kidney/Liver Problem	☐ Lung Problem	☐ Measles/Mumps
☐ Mononucleosis	☐ Nervous Disorder	☐ Psychiatric/Psychological
☐ Rheumatic/Scarlet Fever	☐ Sickle Cell Anemia	☐ Stomach Problem
☐ Tuberculosis	☐ Thyroid Problems	☐ Other

Additional conditions or information we should know about your child:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Guardian:____ Date:____________