Medical and Dental History Form

Patient Name: ______________________________ Date of Birth: ______________

Reason for Visit: ____

Has the patient ever had any of the following?	Yes	No	Comments
Heart Murmur			
Congenital Heart Disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular, or other Endocrine Diseases			
Liver Disease, Hepatitis, Jaundice			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures/Convulsions/Loss of Consciousness			
Cerebral Palsy or other Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, or other Blood Disorders			
Sickle Cell Disease or Traits			
Cancer			
Speech, Hearing, Sight or Eye Disorder (Please Specify)			
Frequent Headaches			
Mental, Emotional, or Developmental Delays			
Autism, ADHD, Genetic Disorder or Syndrome (Please Specify)			
Frequent Infections			
Has the patient ever received blood or blood products			
Has the patient ever been hospitalized?			
Has the patient ever been seriously ill?			
Has the patient ever had any significant injury?			
Has the patient ever had surgery?			
What medicines does the patient take at this time?			
Is the patient allergic to any medicines? (Please Specify)			
Is the patient allergic to any foods or animal/environmental pollutants?			
A Bad Dental Experience?			
Tooth Pain, Mouth/Face Swelling, Face/Mouth Injury			
Does the patient thumb suck or have other oral habits?			
Is your water fluoridated?			

Are there any other medical or dental problems, issues, or conditions we should be aware of?

Please List: ____

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Please list Primary Care Physician(s), Physicians Group, or any Medical Specialists the patient is currently under the care of:

Physician(s): ____

Which of the following best describes the patient's learning abilities? ☐ Delayed ☐ Normal ☐ Advanced

How do you think the patient will do/has done at the dentist? ☐ ☺ ☐ 😑 ☐ ☹

____

Patient/Guardian Signature* Date

*If you are filling out this form prior to your visit, your electronic/typed signature is equivalent to your written signature.
Please email completed forms to colin@kindersmilesco.com