Pediatric Dentistry
MEDICAL HISTORY QUESTIONNAIRE

Patient's Name:_____ Date of Birth:_____

1. Does the patient have any health problems? ___Yes ___No
   If Yes, explain_____
2. Is the patient currently seeing a physician for any problems? ___Yes ___No
   If Yes, explain_____
3. Did the patient have any health problems or illnesses when younger or at birth? ___Yes ___No
   If Yes, explain_____
4. Does the patient take any medications? ___Yes ___No
   If Yes, list (including dose)_____
5. Has the patient ever had any allergic or bad reactions to food or medicines? ___Yes ___No
   If Yes, explain_____
6. Has the patient ever been injured or stayed in the hospital overnight? ___Yes ___No
   If Yes, explain_____
7. Is the patient pregnant or has she been pregnant in the past? ___Yes ___No
   Is the patient on contraceptive pills? ___Yes ___No
8. Has the patient ever had a blood transfusion? ___Yes ___No
9. Has the patient ever had any of the following?
   - blood problems such as sickle cell anemia ___Yes ___No
   - easy bleeding or bruising ___Yes ___No
   - seizures or fainting spells ___Yes ___No
   - frequent headaches ___Yes ___No
   - heart murmur, heart defect or rheumatic fever ___Yes ___No
   - breathing problems or asthma ___Yes ___No
   - frequent cough or tuberculosis (T.B.) ___Yes ___No
   - hepatitis or liver problems ___Yes ___No
   - stomach or bowel problems ___Yes ___No
   - diabetes (sugar), endocrine or hormone problems ___Yes ___No
   - kidney problems ___Yes ___No
   - hives or skin rash ___Yes ___No
   - AIDS or HIV infection ___Yes ___No
   - venereal disease ___Yes ___No
   - birth defect or disability ___Yes ___No
10. Does the patient have any behavior or learning problems? ___Yes ___No
11. What grade at school is the patient in? _____
12. Who takes care of the patient at home? _____
13. Has the patient had any disease, condition or problem not listed above? ___Yes ___No
14. Is the patient presently smoking, chewing or snuffing tobacco? ___Yes ___No
    If Yes, explain_____

Name of the patient's pediatrician or family physician_____
Address _____Phone #_____
Date of last physical examination _____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
(PLEASE SIGN BELOW)

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Reviewer Date