CHILD'S MEDICAL HISTORY

Medical Alert

Child's general health (please Check (✓) one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician's name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Child's last complete physical _____

Has your child been under the care of a medical doctor during the past two years? ..... ☐ Yes ☐ No

If yes, for what? _____

Is your child receiving any medication now? ☐ Yes ☐ No For what purpose? _____

Does your child have any medicine allergies? ☐ Yes ☐ No If so, please list with reaction _____

_____

Is your child allergic to: ☐ Food ☐ Pollen ☐ Animals ☐ Dust ☐ Other _____

Is your child subject to prolong bleeding? ..... ☐ Yes ☐ No

If yes, please list _____

Does your child have good physical coordination? ..... ☐ Yes ☐ No

Does your child have any emotional problems? ..... ☐ Yes ☐ No

Indicate which of the following your child has had or currently has: Circle "Yes" or "No" to each item.

Anemia	Yes	No	Jaundice	Yes	No
Asthma or Hay Fever	Yes	No	Kidney Problems	Yes	No
Abnormal Blood Pressure	Yes	No	Latex Sensitivity	Yes	No
Bladder Problems	Yes	No	Malignancies	Yes	No
Cerebral Palsy	Yes	No	Mastoid	Yes	No
Chronic Sinus	Yes	No	Measles	Yes	No
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No
Cough	Yes	No	Mononucleosis	Yes	No
Diabetes	Yes	No	Mumps	Yes	No
Epilepsy	Yes	No	Radiation Treatment	Yes	No
Fainting	Yes	No	Rheumatic Fever	Yes	No
Glaucoma	Yes	No	Serious Accident	Yes	No
Hearing Problems	Yes	No	Sinus Trouble	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No
Hepatitis	Yes	No	Ulcers	Yes	No
HIV / Aids	Yes	No			

Please describe any current medical treatment including drugs, pending surgery, recent injuries or other information we should be aware of that has not been discussed _____

_____

CHILD'S DENTAL HISTORY

Date of child's last dental visit? _____ Dentist Name _____ Phone_____

Did your child have x-rays taken? ☐ Yes ☐ No Date _____ Has child had all teeth x-rayed in the last three years? ☐ Yes ☐ No

Has your child complained about dental problems?	Yes	No
Has your child had any unhappy dental experiences?	Yes	No
Has your child had any injuries to the mouth, teeth, or head?	Yes	No
Has your child ever worn any orthodontic appliances?	Yes	No
Does your child have any mouth habits, i.e. Thumbsucking, nail biting, mouth breathing, etc.	Yes	No
Does your child have any unusual speech habits?	Yes	No
Does your child brush his/her teeth daily?	Yes	No
Do you assist with tooth brushing?	Yes	No
Is dental floss used?	Yes	No
Is flouride taken in any form?	Yes	No

What is child's attitude toward dentistry? _____

Do you desire complete dental service for your child?	Yes	No

Please add anything you feel is important for the doctor to know _____

I hereby authorize payment to Progressive Dental of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Progressive Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Parent or Guardian's Signature _____ **Date** _____