



ASSOCIATES IN PEDIATRIC DENTAL CARE  
Infants • Children • Teens • Special Needs

# Medical History Form

Acct# \_\_\_\_\_

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female

## Has your child ever had the following medical problems? (Please check Y or N)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia              | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Tumor         | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairments | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous Disorder      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma              | <input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Palsy       | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur        | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Infection |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHA            | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy             | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems      | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Anemia    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays  | <input type="checkbox"/> Y <input type="checkbox"/> N Developmental Delays | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Delays         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autism              | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes             | <input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS            | <input type="checkbox"/> Y <input type="checkbox"/> N Vision Problems       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Behavioral Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/Dizziness   | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease      | <input type="checkbox"/> Y <input type="checkbox"/> N Other _____           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorder   | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis            | <input type="checkbox"/> Y <input type="checkbox"/> N Learning Disability |   |

Please discuss any above medical problems that you marked "yes" in the space provided:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medication your child is currently taking: \_\_\_\_\_

Is your child allergic to:  Penicillin  Latex  Anesthetics  Codeine  Metals  Other \_\_\_\_\_

Are your child's immunizations up to date?  Yes  No

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

## CHILD'S DENTAL HISTORY

What is your chief concern regarding your child's dental health? \_\_\_\_\_

Is your water source  City or  Well?

Do you have a reverse osmosis system?  Yes  No

Is your child taking fluoride supplements?  Yes  No

Does your child use a fluoride rinse?  Yes  No

Parent's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

## Does your child do any of the following?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing                  | <input type="checkbox"/> Y <input type="checkbox"/> N Bottle/Sippy Cup | <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pacifier             | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding/Clenching Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrusting | <input type="checkbox"/> Y <input type="checkbox"/> N Pain in Jaw (TMD) |

## AUTHORIZATION

The health history information provided above is true and complete to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's dental health or other information.

\_\_\_\_\_  
Signature of Parent or Guardian Date Staff Initials

## HEALTH HISTORY UPDATE

Signature _____	Date _____	Staff _____	Signature _____	Date _____	Staff _____
Signature _____	Date _____	Staff _____	Signature _____	Date _____	Staff _____
Signature _____	Date _____	Staff _____	Signature _____	Date _____	Staff _____
Signature _____	Date _____	Staff _____	Signature _____	Date _____	Staff _____

Kay L. Wilson, DDS

Diplomate, American Board of Pediatric Dentistry | Fellow, American Academy of Pediatric Dentistry

1303 Packard Street | Suite 301 | Ann Arbor, MI 48104 | 734-662-1591 | [www.drkaywilson.com](http://www.drkaywilson.com)