Health History

Patient Name: ____ Birthdate: _____________________________

Has your child had any history of:

□ Sinus Problems	Autism	High Blood Pressure	Respiratory Disorder
Brain/Nervous Disorder	Diabetes	Rheumatic Fever	__________________ Syndrome
Thyroid Disease	Allergies	Cerebral Palsy	Excessive Bleeding/Hemophilia
Hepatitis B or C	Ulcers	Heart Murmur	Psychiatric Care
Epilepsy/Seizures	AIDS/HIV	Heart Problems	Cancer/Chemotherapy
Tuberculosis	ADD/ADHD	Lung Disease	Cold Sores/Fever Blisters
Kidney/Liver Problems	Asthma	Hearing Impairments	

Patient attends or has attended:

Occupational Therapy   Physical Therapy   Speech Therapy

Has your child ever had an unfavorable reaction to any of the following? If YES, please explain:

Antibiotics______________________________ Latex______________________________

Any metals______________________________ Food______________________________

Local Anesthetic__________________________ Nuts______________________________

Medications______________________________ Other______________________________

Medical History:

Is the child taking any current medications: ____

____

Has your child had any serious illness not listed above: _______________________________________

Has your child even been hospitalized: ____

Primary care doctor name: _________________________________ Phone#: _______________________________

Date of last medical exam: ______________________

Dental History:

What is the purpose of your child's dental visit with us today?

Check up & Cleaning   Exam only   2nd Opinion   Mouth/Tooth pain

Child's 1st visit to dentist   Trauma/Accident   Other

Date of the last dental visit: __________________   Name of previous Dentist: ____________________________

Has your child had any history of:

Toothaches   Tongue Thrusts   Pacifier use   Lip sucking/biting

TMJ (jaw pain)   Bleeding Gums   Nail Biting   Clenching/Grinding

Thumb/Finger Sucking   Sensitive to hot/cold

Has your child ever had an unfavorable experience with any previous dental work before?

____

Does your child: Brush daily? Yes No   Floss daily? Yes No

Signature of parent/guardian: ____ Date: ____________________

Relationship to patient: ______________________________________

Andrea Myers, DDS, MSD
2200 Olympic Street * Springfield, OH 45503 * 937.390.0493