HAMILTON CO. PEDIATRIC DENTISTRY

Child's Full Name: ____ DOB: _____ / _____ / _____
Gender: Male Female Race/Ethnicity: ______________ Height: _______ Weight: ________
Name/Phone of Primary Physician: ____
Name/Phone of any Medical Specialist: ____

Question	Yes	No
Is your child being treated by a physician at this time?......... If yes, describe reason:	Yes	No
Is your child taking any medications (prescription or over the counter)?......... If yes, list name/dosage/frequency/reason:	Yes	No
Has your child ever been hospitalized or undergone surgery?......... If yes, list dates and describe:	Yes	No
Has your child ever had a reaction to medication, foods, metals, latex, or dyes?......... If yes, list and describe reaction:	Yes	No
Is your child up to date on immunization?.........	Yes	No

Please mark YES if your child has a history of the following:

Condition	Yes	No
Complications before or during birth, prematurity, birth defects, or syndromes.........	Yes	No
Problems with physical growth, development, or failure to thrive.........	Yes	No
Sinusitis, chronic tonsil infections, sleep apnea, or snoring.........	Yes	No
Congenital heart defect/disease, heart murmur, rheumatic fever or disease.........	Yes	No
Irregular heart beat, high or low blood pressure.........	Yes	No
Asthma, reactive airway disease, cystic fibrosis, or breathing problems.........	Yes	No
Frequent colds, coughs, or history of pneumonia.........	Yes	No
Jaundice, hepatitis, or liver problems.........	Yes	No
Gastroesophageal reflux disease (GERD), stomach ulcers, or intestinal problems.........	Yes	No
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions.........	Yes	No
Prolonged diarrhea, unintentional weight loss/gain, or eating disorder.........	Yes	No
Bladder or kidney problems.........	Yes	No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems.........	Yes	No
Rash/hives, eczema, or skin problems.........	Yes	No
Impaired vision, hearing, or speech.........	Yes	No
Developmental disorders, learning problems/delays, or intellectual disability.........	Yes	No
Cerebral palsy, brain injury, epilepsy, or seizures.........	Yes	No
Autism or autism spectrum disorder.........	Yes	No
Recurrent or frequent headaches/migraines, fainting, or dizziness.........	Yes	No
Hydrocephaly or placement of a shunt (VP, VA, VV).........	Yes	No
Attention deficit/hyperactivity disorder (ADD/ADHD).........	Yes	No
Behavioral, emotional, communication, or psychiatric problems/treatment.........	Yes	No
Abuse (physical, emotional, psychological, or sexual) or neglect.........	Yes	No
Diabetes, hyperglycemia, or hypoglycemia.........	Yes	No
Precocious puberty or hormonal problems.........	Yes	No
Thyroid or pituitary problems.........	Yes	No
Anemia, sickle cell trait/disease, or blood disorder.........	Yes	No
Hemophilia, easy bruising, or excessive bleeding.........	Yes	No
Transfusions or receiving blood products.........	Yes	No
Cancer, tumor, other malignancy, chemotherapy, or radiation therapy.........	Yes	No
Bone marrow or organ transplant.........	Yes	No
Mononucleosis, tuberculosis, scarlet fever, or cytomegalovirus.........	Yes	No
MRSA, sexually transmitted disease, HIV/AIDS.........	Yes	No
Any other significant medical history we should be told?.........	Yes	No
If yes, please describe:____	Yes	No

Doctor's Notes:

Doctor Signature: ____ Date: ________________