

PATIENT MEDICAL HISTORY FORM FOR PATIENTS *UNDER* THE AGE OF 18

Full Legal Name: _____ Date of Birth: _____

Primary Care Physician _____ Specialist(s) _____

Last Dental Visit _____ Date of last x-rays _____

Name/Address Previous Dentist _____

DENTAL HISTORY

PLEASE Mark Y (yes) or N (no) for each item

Are you having discomfort today	Y N	Loose/Broken Teeth	Y N	Sores or growth in mouth	Y N
Bleeding/Swollen Gums	Y N	Sensitivity to HOT	Y N	Biting Pain /Pressure	Y N
Bad Breath	Y N	Sensitivity to COLD	Y N	Broken Fillings	Y N
Grinding or Clenching Teeth	Y N	Sensitivity to SWEETS	Y N	Clicking/Popping Jaw	Y N

How often does your child brush? _____ Floss? _____

How do you/your child feel about his/her smile or the appearance of their teeth? _____

Has your child ever had an adverse reaction related to dental treatment? _____

Has your child ever used whitening products or 'bleached' your teeth? _____

Do you or your child have anxiety about dental treatment? _____

Dental concerns or questions? _____

MEDICAL HISTORY

PLEASE Mark Y (yes) or N (no) for each item

Pregnant Now	Y N	Reflux/GERD	Y N	Bulimia	Y N	Legally Deaf	Y N	Hemophilia	Y N
Nursing Now	Y N	Unexplained Fever	Y N	Anorexia	Y N	Legally Blind	Y N	Herpes	Y N
Jaw Pain	Y N	Tuberculosis	Y N	Fainting/Dizziness	Y N	ADD/ADHD	Y N	Allergies to Metals	Y N
High Blood Pressure	Y N	Hepatitis	Y N	Epilepsy/Seizures	Y N	Anxiety/Depression	Y N	Sinus Trouble	Y N
Low Blood Pressure	Y N	Diabetes	Y N	Thyroid Disease	Y N	Nervousness	Y N	Nasal Allergies	Y N
Artificial Heart Valve	Y N	Fam Hist Diabetes	Y N	Kidney Disease	Y N	Shingles	Y N	Food Allergies	Y N
Pacemaker	Y N	Cancer	Y N	Liver Disease	Y N	Tonsillitis	Y N	Drug Use / Addiction	Y N
Heart Surgery	Y N	Radiation	Y N	Anemia	Y N	Facial Pain	Y N	Cocaine Use	Y N
Surgical Implant	Y N	Chemotherapy	Y N	Sickle Cell Anemia	Y N	Smokeless Tobacco	Y N	Methamphetamine Use	Y N
Asthma	Y N	Ulcers/Colitis	Y N	AIDS	Y N	Cigarettes	Y N	Latex Allergy	Y N
Hiatal Hernia	Y N	Esophageal Problems	Y N	HIV positive	Y N	Cigar/Pipe Use	Y N	Ever had an anaphylactic reaction	Y N

****PLEASE ANSWER EACH QUESTION. MARK "N/A" IF THE QUESTION DOES NOT APPLY. ****

Do any of these conditions require pre-medication (prophylactic antibiotic)? _____

Other illness or needs _____

Known allergies to medication(s): _____

Current medication(s): _____

Medicines prescribed for you, but you are NOT taking: _____

Herbs and/or Over The Counter Medications you are taking _____

Any hospitalizations within the past 2 years? If so, for what _____

Would you like to discuss anything privately with the Doctor? YES NO

I hereby attest the above information is accurate. I also give permission to the doctor and staff of this office to contact my medical doctor(s) and other health professionals for the protection of my child's health. This may include sending a copy of this form and/or x-rays.

Parent/Guardian Signature

Date

Reviewed By

Date

Frederick R. Levine, D.D.S.

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