Medical Information

Child's Pediatrician_____Phone_____
Approximate date of last physical____/____/____

Yes	*No*	
□	□	Is your child in good health?
□	□	Are your child's immunization, including tetanus, up to date?
□	□	Is your child being treated for any condition presently? *If so, please explain_____
□	□	Is your child taking any medications? *If so, what & how often?_____
□	□	Has your child ever been hospitalized or had surgery? *If so, Please explain_____
□	□	Does your child have any allergies to the following? □Pollen □Foods □Food Dyes □Latex □Dust □Aspirin □Penicillin □Sulfa □Other_____ *If so, Please explain_____
□	□	Has your child's physician or a cardiologist informed you of your child's need to be placed on prophylactic antibiotics prior to his/her dental procedures? *If so, which drug?_____
□	□	Did your child have a history of health problems at birth or during initial years?
□	□	Has any member of the family had a problem with general anesthetic?
□	□	Does your child have any problems with recurrent headaches? *Medications/Dosage_____
□	□	Have your child's tonsils or adenoids been removed? *If so, when_____
□	□	Is your child physically or mentally disabled? *If so, please describe_____
□	□	Does your child have a learning or behavior problem? (ADD/ADHD etc)? *If so, please describe_____
□	□	Do you wish to speak to the doctor privately about a problem?

Continued on back

Has your child ever been diagnosed as having any of the following conditions?

□AIDS/HIV	□Cleft Lip/Palate	□Hearing/Speech Problems
□Allergies	□Congenital Heart Lesion	□Heart Murmur/Defect
□Anemia	□Convulsions/Seizures	□Hemophilia
□Arthritis	□Developmentally Delayed	□Hepatitis or Liver Disease
□Asthma	□Diabetes	□High Blood Pressure
□Lung Problems	□Drug Addiction	□Kidney Disease
□Autism	□Ear Stuffiness, Itching or Noises	□Leukemia
□Bladder Conditions	□Emotional Disturbance	□Nutritional Deficiency
□Blood Disease	□Endocrine System	□Oral Ulcers
□Bleeding Disorders	□Epilepsy	□Orthopedic Problems
□Blood Trans Date___/___/___	□Eye Problem	□Pain in Jaw Joints
□Birth Defects	□Excessive Bleeding	□Premature Birth-how early?
□Bone or Joint Problems	□Excessive Gagging	□Psychiatric Care
□Brain Injury	□Fainting or Dizziness	□Rheumatic Fever
□Bruising Easily	□Fever Blisters	□Scoliosis
□Cancer or Malignancies	□Fetal Alcohol Syndrome	□Sickle Cell Anemia
□Cerebral Palsy	□Growth & Development Problems	□Sydrome_____
□Chemotherapy/Radiation	□GI Disorder	□Tuberculosis
□Child Abuse	□Heart Surgery	□Other_____

Comments/Explanations must be given for all checked boxes_____

Yes	***No***	
□	□	Was your child bottle fed? If so, until what age?_____
□	□	Was your child breast fed? If so, until what age?_____
□	□	Has your child ever suffered any trauma to his/her teeth, mouth, head, neck or jaws? *If so, please describe_____
□	□	Does an adult assist with brushing?
□	□	Does your child floss daily?
□	□	Does an adult assist with the flossing?
□	□	Does your child have any of the following mouth habits? □Finger sucking □Thumb □Pacifier □Tongue thrust □Lip sucking □Mouth breather □Grinding □Nail biting
□	□	Does your child report any jaw pain or discomfort while chewing, opening wide or upon awakening?
□	□	Does your child receive fluoride in any of the following forms? □Vitamins □water supply □toothpaste □rinse/gel □prescription drops/tabs dosage_____mg/day

*Please check any of the following that may describe your child:
□outgoing □shy □stubborn □anxious □frightened □defiant □curious □moody □high strung □friendly □cooperative
*How do you expect your child to react to his/her visit?
□excellent □good □poor □don't know
*How may we help to make this a positive experience for your child?_____

Consent for Treatment

As parent or guardian, I understand that all proposed treatment will be reviewed and explained to me prior to being performed. I consent to Dr. Yee-Lo and her staff performing the reviewed procedures for my child.

***Signature_____Date_____Relationship to Patient_____**
Reviewed by _____
Office Staff