Somerset Dental Associates
Come smile with us!

1590 North Center Avenue, Suite 102 • Somerset, PA 15501
865 Eisenhower Boulevard, Complex 2 • Johnstown, PA 15904
814.444.0850

MEDICAL HISTORY-CHILD

Patient Name
(Please Print):____ **Date of Birth**:____________

____Allergy Latex
____ADD/ADHD
____Artificial Heart Valve
____Asthma
____Cancer
____Diabetes
____Emphysema
____Fainting
____Head Injuries
____Heart Murmur
____High Blood Pressure
____Kidney Disease
____Malignant Hyperthermia
____Pacemaker
____Pregnancy
____Rheumatic Fever
____Seizures
____Stomach Problems
____Tuberculosis

____Venereal Disease
____AIDS/HIV
____Anemia
____Arthritis
____Autism
____Cerebral Palsy
____Dizziness
____Epilepsy
____High Cholesterol
____Headaches
____Heart Problems
____Jaundice
____Liver Disease
____Mitral Valve Prolapse
____Parkinson's Disease
____Radiation Treatment
____Rheumatism
____Sinus Problems
____Stroke

____Tumors/Growths
____Angina
____Artificial Joints
____Blood Disease
____Dental Complications
____Downs Syndrome
____Excessive Bleeding
____Glaucoma
____Heart Disease
____Hepatitis
____Lung Disease
____Nervous/Mental Disorder
____Pre-Medicate
____Respiratory Problems
____Shortness of Breath
____Smoke/Chew
____Thyroid Problems
____Ulcers
____Allergy Metal

1. **Do you have any drug allergies?** YES NO **If yes, please list:**
____
____

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2. Name of family physician?

___

3. Is the child taking any medications at this time? YES NO If yes, please list or present a copy of the medications.

___

___

4. Has the child ever had a serious illness? YES NO If yes, please describe.

___

___

5. Has the child ever been hospitalized? YES NO

6. Does the child have any speech difficulties? YES NO

7. Does the child experience excessive bleeding when cut? YES NO

8. Is this the child's first visit to the dentist? YES NO

9. Has the child had any difficulties with dental treatment in the past? YES NO

10. Has the child ever had dental x-rays? YES NO

11. Has the child ever suffered any injuries to the mouth, head or teeth? YES NO

12. Has the child ever had any problems when losing baby teeth or when permanent teeth have come in?

    YES NO

13. Has the child ever had any orthodontic treatment? YES NO

14. What type of water does the child drink?

    BOTTLED WATER WELL WATER TOWN WATER SPRING WATER

15. Does the child take fluoride supplements? YES NO

16. How many times per day does the child brush his/her teeth? ONE TWO THREE

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17. Does the child suck on any of the following?

    THUMB FINGERS PACIFIER BLANKET

18. Does the child have any condition not previously mentioned? YES NO If yes, please describe.

____

19. What pharmacy do you use and where is it located?

____

20. How were you referred to this office?

____

21. Race (please check all that apply)

____ African American
____ White
____ Other
____ Asian
____ Native American
____ I refuse to answer.
____ Alaskan Native
____ Native Hawaiian
____ Hispanic
____ Other Pacific

Parent/Guardian is encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other staff member, responsible for any action they take because of errors or omissions that I may have made in the completion of this form.

Parent/Guardian Name (please print): ____

Parent/Guardian Signature:

____

Date: ______________________________