Health History Information

Patient Name: _____

Pediatrician / Primary Care Physician: _____

Current Medications: _____ □ NONE

Please CHECK all that apply

Allergies to:
□ Medication: _____
□ Food: _____
□ Latex
□ Other: _____
□ NONE

Respiratory:
□ Asthma
□ TB (Tuberculosis)
□ Cystic Fibrosis
□ Bronchitis
□ Other: _____
□ NONE

Ears/Nose/Throat:
□ Large tonsils
□ Sleep apnea with nightly snoring
□ Narrow Airway
□ Difficulty swallowing
□ Seasonal Allergies
□ Sinus Infection
□ Other: _____
□ NONE

Cardiac:
□ Congenital abnormality: _____
□ Heart Condition: _____
□ High Blood Pressure
□ Valve dysfunction: _____
□ NONE

Hematology/Oncology/Other:
□ Anemia (requiring treatment)
□ Bleeding Disorder: _____
□ MRSA or other infectious disease:
□ Sickle Cell Disease
□ Cancer: _____
□ HIV/AIDS
□ Other: _____
□ NONE

GI/GU:
□ GERD/acid reflux
□ Hiatal hernia
□ Abdominal Pain: _____
□ Hepatitis/Liver transplant
□ Other: _____
□ NONE

Endocrine/Metabolic:
□ Diabetes-Type 1 / Type 2
□ Hypothyroid/Hyperthyroid
□ Kidney Transplant
□ Metabolic Syndrome
□ Other: _____
□ NONE

Neurological/Musculoskeletal:
□ Seizures/Epilepsy
□ Cerebral Palsy
□ Muscular Dystrophy
□ Low muscle tone/Paralysis
□ Arthritis
□ Headaches
□ Neuromuscular disease
□ Other: _____
□ NONE

Psychosocial/Social:
□ Developmental Delay: _____
□ Growth Concerns: _____
□ ADD/ADHD
□ Autism
□ Other: _____
□ NONE

Are there any medical conditions not listed above that you feel we should be aware of? Yes No

If yes, please explain: _____

Dental / Orthodontic Information

Does the patient see another dentist for routine care? If yes, who? _____

Has the patient had a professional dental cleaning in the last 6 months? Yes No

What are the main dental / orthodontic concern(s) you would like to address? _____

Signature: _____ Date: _____