

BASIC CHILD GENERAL HEALTH INFORMATION

It is important that we understand your child's health history, as it has a direct bearing on dental health in general and safety during treatment. This information is confidential and is not released to anyone without your permission.

Thank you for helping us take good care of your child.

Person Completing This Form: _____ Relationship To Child _____

Child's Name _____ Today's Date ____/____/____

Does your child have a medical situation which you prefer to only discuss privately with the doctor? NO YES

Does Your Child Have, or Has Your Child Ever Had, Any Of The Following:

YES NO
(please check YES or NO for EACH item)

- Heart Attack or Heart Disease
- Angina Pectoris (Chest Pain)
- Heart Murmur
- Mitral Valve Prolapse
- Congenital Heart Lesion
- Artificial Heart Valve
- Heart Pacemaker
- Heart Surgery
- Rheumatic Fever
- High Blood Pressure
- Low Blood Pressure (Chronic)
- Stroke
- Diabetes (which type?) _____
- Hypoglycemia (Low Blood Sugar)
- Hepatitis A (Infectious Hepatitis)
- Hepatitis B (Serum Hepatitis)
- Hepatitis C Or Other Form Of Hepatitis
- Any Other Liver Disease Or Jaundice
- Any Kind Of Kidney Disease Or Disorder
- Anemia
- Any Other Blood Disorder
- Episodes of Prolonged Bleeding
- Any Other Bleeding Problem
- Bruise Easily
- Bone Or Calcium Disorder
- Epilepsy Or Other Seizure Disorder
- Chronic Bronchitis Or Emphysema (which?)
- Asthma
- Lyme Disease
- Tuberculosis (TB)
- Any Other Lung Or Respiratory Problem

YES NO
(please check YES or NO for EACH item)

- Enlarged Tonsils or Adenoids
- Significant Snoring (Has Disturbed Others)
- Sleep Apnea (Diagnosed by MD or Sleep Lab)
- Hay Fever
- Thyroid Disease Or Disorder
- Artificial Joint (Hips, Knees, Other)
- Arthritis
- Pain In Jaw Joint(s)
- Frequent Or Chronic Headaches
- Nerve or Neurological Problem
- Just Plain Depressed A Lot
- Ulcer Or Other Gastro-Intestinal Disorder
- Glaucoma Or Other Eye Disease
- Skin Or Dermatologic Problem
- Cortisone Treatment
- Venereal Disease
- Herpes
- Frequent Cold Sores Or Fever Blisters
- Alcoholism
- Any Other Drug Or Chemical Dependency
- HIV Positive
- AIDS
- Tumor Or Malignancy (Cancer)
- _____
- Radiation Treatment Or Chemotherapy
- Surgery In The Past Five Years
(What? _____)
- Other Medical Or Health Problem (what is it?)



PLEASE COMPLETE THE OTHER SIDE ALSO



Basic Child General Health Information (Continued)

What Is Your Child's Height? _____ Present Weight? _____

Does Your Child Regularly Participate In Contact Sports Or Athletics? NO
 YES (please list which ones):

Is Your Child Allergic To Or Reacted Badly To Any Of The Following:

(please circle which)

Allergic: Aspirin Codeine Local Anesthetic Nitrous Oxide Penicillin Erythromycin
 Reacted Badly: Aspirin Codeine Local Anesthetic Nitrous Oxide Penicillin Erythromycin

Are Your Child Allergic To Latex? No Yes (please give details):

Is Your Child Allergic Or Reacted Badly To Anything Else? No Yes (please give details):

Please List, As Specifically As Possible, Any And All Drugs And Medications, Prescription Or Not, That Your Child Currently Takes Or Regularly Uses.

Child's Physician: _____
(Address) _____

I authorize Dr. Ross to discuss my child's health status in connection with his or her dental treatment with my child's doctors and authorize those doctors to discuss my child's health with Dr. Ross.

Your Signature, Please _____ Date ____/____/____

Reviewed by Doctor _____ Date ____/____/____

**Please Inform Us Of All Changes In Your Child's Health So We May
Care For Him Or Her Safely And Effectively. Thank You.**