Naples Pediatric Dentistry
Medical History

Patient Name _____

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Name of your child's pediatrician or family physician _____

Is your child under the care of a physician now? Yes ___ No ___

Has your child ever been hospitalized or had a major operation? Yes ___ No ___

Has your child ever had a serious head or neck injury? Yes ___ No ___

Is your child taking any medications, pills or drugs? Yes ___ No ___

If yes, please list: _____
Is your child on a special diet? Yes ___ No ___

If yes, please describe: _____
Does your child use tobacco? Yes ___ No ___

Is your child allergic to any of the following?

	Aspirin		Penicillin		Amoxicillin		Codeine		Latex		Local Anesthetics		Other

If other, please list _____

Does your child have or has your child had any of the following?

	AIDS/HIV positive		Eating Disorder		Immunological Problems		Sickle Cell Disease
	Anaphalaxis		Epilepsy or Seizure		Kidney Problems		Spina Bifida
	Anemia		Excessive Bleeding		Learning Disorder		Stomach Diseases
	Asthma		Excessive Thirst		Leukemia		Intestinal Diseases
	Cancer		Frequent Ear Infection		Liver Disease		Thyroid Disease
	Cleft Lip or Palate		Hearing Impairment		Neurological Problems		Tonsillitis
	Cold Sore/Fever Sore		Heart Murmur		Respiratory Problems		Tuberculosis
	Diabetes		Heart Trouble/Disease		Rheumatic Fever		Tumors/Growths
	Digestive Disorder		High Blood Pressure		Scarlet Fever		Visual Impairment

Has your child ever had any serious illness not listed above? Yes _____ No ____

If yes, what illness or additional comments regarding above :

_____
_____
_____
_____