ALABASTER SMILES
PEDIATRIC DENTISTRY

Medical History

Patient Name: ____________________**DOB:**__________

Is the patient:
Currently under the care of a physician? ☐ Y ☐ N
If yes, what is the condition being treated? ____________
____
Physician Name: ______________________________
Physician's Phone #: ____________________________
Up to date with immunizations? ☐ Y ☐ N
Currently taking any medications? ☐ Y ☐ N
If yes, please list:
____
____
Preferred Pharmacy? ________________________________

Address: ____
Phone Number: __________________________________
Email Address: __________________________________

Has the patient:
Had any serious illness, operation, or been hospitalized in the last five years? ☐ Y ☐ N
If yes, explain: ___________________________________
____
Ever had a serious head or neck injury? ☐ Y ☐ N
If yes, explain: __________________________________
____
Ever complained of TMJ discomfort? ☐ Y ☐ N

Allergies
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetic
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Nitrous Inhalation
- ☐ Penicillin
- ☐ Plastics
- ☐ Red Dye
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Food Allergies:
____
____
- ☐ Other Allergies:
____
____

Medical History
- ☐ ADD/ADHD
- ☐ AIDS or HIV Infection
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral Challenges
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Cleft Lip/Palate
- ☐ Congenital Heart Defect
- ☐ Craniofacial Anomalies
- ☐ Diabetes - Type 1 or Type 2
- ☐ Depression/Anxiety
- ☐ Drug/Alcohol Abuse
- ☐ Eating Disorder
- ☐ Emphysema or COPD
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Gene Mutation
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ MTHFR gene mutation
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Physical Disability
- ☐ Pregnant
- ☐ Psychiatric Care
- ☐ Radiation
- ☐ Sensory Disorder
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Issues
- ☐ Stomach Issues
- ☐ Stroke
- ☐ Thyroid Hyper/Hypo
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: ______________

Pediatric Habits
- ☐ Clenching/Grinding
- ☐ Lip Sucking
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ Nursing Bottle Habit
- ☐ Pacifier Habit
- ☐ Snoring
- ☐ Thumb/Finger Sucking

I certify to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Patient or Guardian: ____ **Date:** ____________________