COLLEGE OF DENTISTRY
The UNIVERSITY of OKLAHOMA HEALTH SCIENCES

PEDIATRIC DENTISTRY SPECIALTY CLINIC - PATIENT MEDICAL HISTORY

_____

Patient's Full Legal Name (First Middle Last)

_____

Patient's Date of Birth

Is your child currently under the care of a physician for a specific medical problem?
( ) Yes ( ) No If yes, describe_____

Does your child have a primary care physician?
( ) Yes ( ) No If yes, list_____

Has your child ever been hospitalized or had surgery?
( ) Yes ( ) No If yes, describe_____

Is your child currently taking any medications or supplements?
( ) Yes ( ) No If yes, list_____

Does your child have any allergies to medications, metals, latex, or anesthetics?
( ) Yes ( ) No If yes, describe_____

Are your child's immunizations up to date?
( ) Yes ( ) No If no, explain_____

Does any member of your family, including your child, have issues with general anesthesia?
( ) Yes ( ) No If yes, describe_____

Has your child ever had dental or facial trauma?
( ) Yes ( ) No If yes, describe_____

Does your child have any oral habits?
( ) Yes ( ) No If yes, describe_____

Continued on Reverse

Does your child have, or have they had, any of the following?

( ) AIDS/HIV
( ) Anemia
( ) Arthritis
( ) Asthma
( ) Autism
( ) Bladder Condition
( ) Blood Disorder
( ) Blood Transfusion
( ) Birth Defect
( ) Bone or Joint Problem
( ) Brain Injury
( ) Bruises Easily
( ) Cancer or Malignancy
( ) Cerebral Palsy
( ) Chemotherapy
( ) Child Abuse or Neglect
( ) Chronic Infections
( ) Chronic Headaches
( ) Cleft Lip / Palate
( ) Congenital Heart Disease
( ) Convulsions / Seizures
( ) Developmental Delays
( ) Diabetes
( ) Ear Problem
( ) Eye Problem
( ) Excessive Gagging
( ) Fainting or Dizziness
( ) Fever Blisters / Cold Sores
( ) Gastrointestinal Disease
( ) Growth Problems
( ) Hearing Impairment
( ) Heart Murmur or Defect
( ) Hemophilia
( ) Hepatitis
( ) High Blood Pressure
( ) Hyperactivity / ADHD
( ) Immune Suppression
( ) Kidney Disease
( ) Liver Disease
( ) Neurologic Problem
( ) Nutritional Deficiency
( ) Pain in Jaw Joints
( ) Pregnancy
( ) Premature Birth
( ) Psychiatric Diagnosis
( ) Radiation Treatment
( ) Sensory Issues
( ) Sickle Cell Disease
( ) Speech Disorder
( ) Thyroid Disease
( ) Vision Impairment
( ) Syndrome
( ) Requires Antibiotics
( ) Requires Blood Products

Does your child have any illness or syndrome not listed above?
( ) Yes ( ) No If yes, describe_____

Do you wish to speak with a doctor privately about any specific concern?
( ) Yes ( ) No If yes, describe_____

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

_____ _____
Signature of Patient (over 18) or Parent/Guardian (under 18) Date