



Pediatric Medical & Dental History

Patient Name _____ Date of Birth ____/____/____

Parents' Names _____

Mailing Address _____ Email _____

Telephone Numbers (H) _____ (C) _____ (W) _____

Name of your child's pediatrician _____ Physician's Phone # _____

Date of most recent physical exam _____

"Whom may we thank for telling you about our office?" _____

- Does your child have any current health problems?.....yes ?no ?
- What medications is your child currently taking?

Has your child ever had a serious illness, operation, or hospitalization?.....yes ?no ?
If yes, please describe _____ When? _____

Has your child ever had, or do they currently have any of the following conditions? (Please circle)

- | | | |
|---------------------------|-------------------------|---------------------|
| Rheumatic Fever | Allergies or Hives | Tumors/Growths |
| Heart Condition | Diabetes | Kidney Disease |
| Heart Murmur | Hepatitis/Liver Disease | Splenectomy |
| Abnormal Blood Pressure | Brain Injury | ADD/ADHD |
| Sickle Cell Disease/Trait | Seizures | Autism |
| Blood Disease | Speech Disorder | Developmental Delay |
| Anemia | Emotional Disorder | Other _____ |
| Tuberculosis | Bleeding Disorder | |
| Lung Disease | Hemophilia | NONE |
| Asthma | Transfusions | |

Is your child allergic to, or has he/she reacted adversely to any of the following: (Please circle)

- | | | |
|--------------------------------|--------------|-------------------------|
| Aspirin | Penicillin | Sedatives |
| Acetaminophen (Tylenol) | Amoxicillin | Latex |
| Nitrous Oxide (laughing gas) | Erythromycin | Other Substances? _____ |
| Local Anesthetic ("Novocaine") | Codeine | NONE |

How long since your last dental visit? _____ Has your child ever had an UNHAPPY dental experience? _____

Is your child having a dental problem now? _____ If yes, please describe _____

Has your child ever had any injuries to the teeth, mouth, or head? _____ If yes, describe _____

Circle any that apply to your child: THUMBSUCKING PACIFIER NAILBITING GRINDING SNORING

Has your child ever taken a bottle or "sippy cup" at naptime or bedtime? _____

To the best of my knowledge, the above questions have been answered accurately. I hereby consent to the initial examination, including the taking of diagnostic radiographs (x-rays), photographs, and casts as deemed necessary by Dr. Callahan.

Signature of Parent/Guardian _____ Date _____