MEDICAL HISTORY

Child's Physician:				
Phone:				
Address:				
City:	State:	Zip:		
Does your child have any health problems?			Yes	No
Has your child seen a physician in the past 12 months?			Yes	No
Has your child been hospitalized or been in the emergency room in the past 12 months?			Yes	No
Is your child under the care of a physician at this time?			Yes	No
Date and reason for last medical examination:				
Is your child taking any medications?			Yes	No
If yes, please list names of medications and dosages				
Were difficulties encountered during pregnancy or delivery of child?			Yes	No
If yes, please explain:				

Does your child have any history of allergic reactions: (Circle all that apply)
Environment (Dust, Pollen) Food Latex Local Anesthetic Medications (Amoxicillin, Penicillin, Sulfa)
Other:_____

Blood and Immune System
□Yes □No Bleeding tendency
□Yes □No clotting disorder
□Yes □No Anemia
□Yes □No Sickle cell anemia or trait
□Yes □No Blood transfusion
□Yes □No Bruising problem
□Yes □No Positive blood test for HIV
□Yes □No Skin blotches or rashes

Heart and Blood Vessels
□Yes □No Congenital Heart Disease
□Yes □No Rheumatic Fever
□Yes □No Heart Murmur
□Yes □No Heart transplant/Valve problem
□Yes □No Pacemaker
□Yes □No Irregular heart beat
□Yes □No High Blood Pressure

Respiratory
□Yes □No Breathing or lung problems
□Yes □No Sinus problems
□Yes □No Asthma
□Yes □No Hay Fever
□Yes □No Frequent nosebleeds

Bones and Muscles
□Yes □No **J**oint pain/arthritis/rheumatism
□Yes □No Prosthetic or artificial joints
□Yes □No Muscular dystrophy
□Yes □No Physical disabilities

Endocrine/GI System/GU System
□Yes □No Diabetes
□Yes □No Family history of diabetes
□Yes □No Thyroid/goiter or adrenal gland problem
□Yes □No Dry Mouth
□Yes □No Hepatitis
□Yes □No Unexplained nausea or vomiting
□Yes □No Intestinal or stomach problems
□Yes □No Unexplained weight loss or gain
□Yes □No Kidney problem
□Yes □No Liver problem
□Yes □No Frequency of urination/bladder disease

Eyes and Ears
□Yes □No Eye problem
□Yes □No Deafness/Hearing loss

Oncology
□Yes □No Tumors/Cancer/Leukemia
□Yes □No Chemotherapy/Radiation therapy

Nervous System
□Yes □No Attention Deficit Disorder
□Yes □No Autism
□Yes □No Brain injury
□Yes □No Cerebral palsy
□Yes □No Convulsion/seizures/epilepsy
□Yes □No Dizziness/problems with balance
□Yes □No Fainting spells/loss of consciousness
□Yes □No Mental problems
□Yes □No Neurological problems
□Yes □No Paralysis/Polio
□Yes □No Psychiatric disorder

Genetic/Developmental
□Yes □No Birth defect
□Yes □No Cleft lip
□Yes □No Cleft palate
□Yes □No Down's Syndrome
□Yes □No Other Genetic disorder
□Yes □No Other Syndrome
□Yes □No Any other medical problem not mentioned

Other
□Yes □No Car/motion sickness
□Yes □No Concentration problems
□Yes □No Cooperating problems
□Yes □No Fear of strangers
□Yes □No Speech problems
□Yes □No Understanding problems

MINOR/CHILD CONSENT
I am the parent, guardian, or personal representative of _____
_____(Please print the name or Minor/child) and there are no court orders now in effect that prohibit me from signing this consent. I understand that the personal/medical/dental information that I have given is complete and correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Date:_____ _____
Signature of Parent, Guardian or Personal Representative

Date:_____ _____
Melba Z. Mayes, D.D.S., M.S.