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	**Bones and Muscles**	**Nervous System**
Yes \ No Bleeding tendency	Yes \ No **J**oint pain/arthritis/rheumatism	Yes \ No Attention Deficit Disorder
Yes \ No clotting disorder	Yes \ No Prosthetic or artificial joints	Yes \ No Autism
Yes \ No Anemia	Yes \ No Muscular dystrophy	Yes \ No Brain injury
Yes \ No Sickle cell anemia or trait	Yes \ No Physical disabilities	Yes \ No Cerebral palsy
Yes \ No Blood transfusion	**Endocrine/GI System/GU System**	Yes \ No Convulsion/seizures/epilepsy
Yes \ No Bruising problem	Yes \ No Diabetes	Yes \ No Dizziness/problems with balance
Yes \ No Positive blood test for HIV	Yes \ No Family history of diabetes	Yes \ No Fainting spells/loss of consciousness
Yes \ No Skin blotches or rashes	Yes \ No Thyroid/goiter or adrenal gland problem	Yes \ No Mental problems
Heart and Blood Vessels	Yes \ No Dry Mouth	Yes \ No Neurological problems
Yes \ No Congenital Heart Disease	Yes \ No Hepatitis	Yes \ No Paralysis/Polio
Yes \ No Rheumatic Fever	Yes \ No Unexplained nausea or vomiting	Yes \ No Psychiatric disorder
Yes \ No Heart Murmur	Yes \ No Intestinal or stomach problems	**Genetic/Developmental**
Yes \ No Heart transplant/Valve problem	Yes \ No Unexplained weight loss or gain	Yes \ No Birth defect
Yes \ No Pacemaker	Yes \ No Kidney problem	Yes \ No Cleft lip
Yes \ No Irregular heart beat	Yes \ No Liver problem	Yes \ No Cleft palate
Yes \ No High Blood Pressure	Yes \ No Frequency of urination/bladder disease	Yes \ No Down's Syndrome
Respiratory	**Eyes and Ears**	Yes \ No Other Genetic disorder
Yes \ No Breathing or lung problems	Yes \ No Eye problem	Yes \ No Other Syndrome
Yes \ No Sinus problems	Yes \ No Deafness/Hearing loss	Yes \ No Any other medical problem not mentioned
Yes \ No Asthma	**Oncology**	**Other**
Yes \ No Hay Fever	Yes \ No Tumors/Cancer/Leukemia	Yes \ No Car/motion sickness
Yes \ No Frequent nosebleeds	Yes \ No Chemotherapy/Radiation therapy	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.