Time 5:17 PM

Jason M. Herrick, DDS, LLC

Date 1/2/2017

# Eaglesoft Child Medical History(Copy)

Patient Name: Birth Date: Date Created:

Your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

| | | |
|---|---|---|
| Is your child under a physician's care now? | Yes No | If yes |
| Has your child ever been hospitalized or had a major operation? | Yes No | If yes |
| Has your child ever had a serious head or neck injury? | Yes No | If yes |
| Is your child taking any medications, pills, or drugs? | Yes No | If yes |
| Is your child on a special diet? | Yes No | |
| Does your child have sleep apnea/snore, mouth breathe, or have gagging problems? | Yes No | |
| Does your child use tobacco? | Yes No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | Cortisone Medicine | Yes No | Hemophilia | Yes No | Radiation Treatments | Yes No |
| Alzheimer's Disease | Yes No | Diabetes | Yes No | Hepatitis A | Yes No | Recent Weight Loss | Yes No |
| Anaphylaxis | Yes No | Drug Addiction | Yes No | Hepatitis B or C | Yes No | Renal Dialysis | Yes No |
| Anemia | Yes No | Easily Winded | Yes No | Herpes | Yes No | Rheumatic Fever | Yes No |
| Angina | Yes No | Emphysema | Yes No | High Blood Pressure | Yes No | Rheumatism | Yes No |
| Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No | High Cholesterol | Yes No | Scarlet Fever | Yes No |
| Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No | Hives or Rash | Yes No | Shingles | Yes No |
| Artificial Joint | Yes No | Excessive Thirst | Yes No | Hypoglycemia | Yes No | Sickle Cell Disease | Yes No |
| Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No | Sinus Trouble | Yes No |
| Blood Disease | Yes No | Frequent Cough | Yes No | Kidney Problems | Yes No | Spina Bifida | Yes No |
| Blood Transfusion | Yes No | Frequent Diarrhea | Yes No | Leukemia | Yes No | Stomach/Intestinal Disease | Yes No |
| Breathing Problems | Yes No | Frequent Headaches | Yes No | Liver Disease | Yes No | Stroke | Yes No |
| Bruise Easily | Yes No | Genital Herpes | Yes No | Low Blood Pressure | Yes No | Swelling of Limbs | Yes No |
| Cancer | Yes No | Glaucoma | Yes No | Lung Disease | Yes No | Thyroid Disease | Yes No |
| Chemotherapy | Yes No | Hay Fever | Yes No | Mitral Valve Prolapse | Yes No | Tonsillitis | Yes No |
| Chest Pains | Yes No | Heart Attack/Failure | Yes No | Osteoporosis | Yes No | Tuberculosis | Yes No |
| Cold Sores/Fever Blisters | Yes No | Heart Murmur | Yes No | Pain in Jaw Joints | Yes No | Tumors or Growths | Yes No |
| Congenital Heart Disorder | Yes No | Heart Pacemaker | Yes No | Parathyroid Disease | Yes No | Ulcers | Yes No |
| Convulsions | Yes No | Heart Trouble/Disease | Yes No | Psychiatric Care | Yes No | Venereal Disease | Yes No |
| Yellow Jaundice | Yes No | | | | | | |

Has your child ever had any serious illness not listed above? Yes No If yes

Comments:

## Dental History

Does your child have a history of any of the following? For each yes respnse, please describe:

| | |
|---|---|
| Inherited dental problem | Yes No |
| Mouth sores or fever blisters | Yes No |
| Bad breath | Yes No |
| Bleeding gums | Yes No |
| Cavities/decay | Yes No |
| Toothache | Yes No |
| Injury to teeth/jaws | Yes No |
| Clenching/grinding | Yes No |
| Jaw or joint problems | Yes No |
| Problems gagging | Yes No |
| Sucking thumb after 1yr old | Yes No |
| Sucking pacifier after 1yr old | Yes No |
| Milk at bedtime | Yes No |

## Oral Hygiene

| | |
|---|---|
| How often does your child brush their teeth per day? | Yes No |
| How often does your child floss their teeth per day? | Yes No |
| Does you house drink tap water with fluoride? | Yes No |

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____