**Medical / Dental History Update**

Child's legal name:_____

Has your child been treated by a physician in the last 6 months? Reason _____ ☐Yes ☐ No

Medical specialist _____ Telephone: _____ Last visit_____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐Yes ☐No

If Yes, list name, dose, frequency & date started _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?

☐Yes ☐No If Yes, list date & describe _____

Has your child ever had a reaction to or problem with an anesthetic? ☐Yes ☐No

Describe_____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? ☐Yes ☐No
List _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? ☐Yes ☐No
List:_____

Have there recently been any significant changes/disruptions to your child's family, home, or school routine? ☐Yes ☐No

If yes, describe _____

What is your primary concern regarding your child's oral health? Describe _____

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? ☐Yes ☐No

If yes, describe _____

Has your child's diet changed significantly since his/her last dental visit? ☐Yes ☐No

Describe _____ _____

Has your child been treated by another dentist/ dental professional since last visiting our office? ☐Yes ☐No

Reason: _____

Is there any other change in the child's medical, dental, or family history that the dentist should be told? ☐Yes ☐No

If yes, describe _____

**Signature of parent / legal guardian_____ Relationship to patient_____ Date _____**

Adapted from "Pediatric Medical History" from the American Academy of Pediatric Dentistry, 2019.