Martin, DDS

Medical History

Last Name: First Name: Birthdate:

Name of Medical Doctor:_________________________________ City/State:_______________________

Emergency Contact_________________ Phone____________ Relationship_______________________

List all medications or drugs you are now taking:

☐ None

List all medications or drugs you are allergic to:

☐ None

List any medical conditions you may have including: asthma, bleeding problems, cancer, HIV/AIDS, diabetes, heart murmur, heart problems, high blood pressure, kidney disease, liver disease,epilepsy, pregnancy, psychiatric treatment, headaches, joint replacement:

☐ None

Does your child have any special needs (ADD, ADHD, Autism, physical challenges, or any syndrome/diagnosis not listed)?

☐ None

Has your child ever been hospitalized? If yes, when and for what condition?

☐ No

Has your child had any surgeries? If yes, what surgeries and were there any complications?

☐ No

Reason for today's visit Are you in pain?

Dental History:

Is this your child's first dental visit?

Has your child experienced any unfavorable reactions from a previous dental visit or medical care?

Has your child had a toothache recently?

Does your child have a history of thumbsucking, fingersucking, lip biting, or nail biting? If yes, please circle which one.