

Medical History

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

	Yes	No		Yes	No		Yes	No
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problem	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Type___	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is your child being treated by a physician at this time?
If yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is your child taking <u>any</u> medications at this time?
If yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your child ever been hospitalized?
If yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is your child allergic to anything? (medicine/food)
If yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have problems in: <input type="checkbox"/> concentrating <input type="checkbox"/> learning <input type="checkbox"/> cooperating <input type="checkbox"/> understanding | | |
| 6. Name of child's physician: _____ Physician's phone #: _____
Date of last visit: _____ | | |
| 7. Is there anything else you think we should know about your child? _____ | | |

Dental History

Is this your child's first dental visit? Yes No

If no, please give date of last examination: _____ Dentist's name: _____

Has your child ever had any of the following? Please check all that apply.

<input type="checkbox"/> Abscesses	<input type="checkbox"/> Toothaches	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Injury to front teeth	<input type="checkbox"/> Finger/Thumb/Pacifier Habit

At what age did your child stop breast/bottle feeding? _____

Are your child's teeth brushed once or more a day? Yes No

Reason for your visit today: _____

Is there anything else you think we should know about your child? _____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Vela and his dental staff to perform an examination, and after explanation, the necessary dental services and those methods deemed appropriate for the care of the above-named child. This consent shall remain in full force and effect until canceled by either party.

Signature of parent or guardian

Relationship to patient

Date