Capital District Pediatric Dentistry
MEDICAL HISTORY UPDATE

Patient Name_____ **Date of Birth**_____

Does your child have any medical condition that they may have or are being treated for?

_____

_____

Please list all of your child's current medications, dose and frequency:

_____ _____

_____ _____

_____ _____

_____ _____

Please list all of your child's allergies: seasonal, medication, food, etc.

_____

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? PLEASE CIRCLE NUMBER:

1. ADENOIDECTOMY
2. ADD/ADHD
3. ANEMIA
4. ASTHMA
5. AUTISM SPECTRUM
6. BLADDER PROBLEMS
7. BLEEDING PROBLEMS
8. CANCER
9. CEREBRAL PALSY
10. CONTINUOUS COLDS
11. DIABETES
12. DOWN SYNDROME
13. EPILEPSY
14. HEARING PROBLEMS
15. HEART DISEASE
16. HEMOPHILIA
17. HEPATITIS
18. HOSPITALIZATIONS
19. KIDNEY PROBLEMS
20. LEUKEMIA
21. LIVER DISEASE
22. LUNG DISEASE
23. MONONUCLEOSIS
24. PNEUMONIA
25. RHEUMATIC FEVER
26. SCARLET FEVER
27. SEIZURE DISORDER
28. SPEECH PROBLEMS
29. SURGERY
30. TONSILECTOMY
31. TUBERCULOSIS
32. TRANSFUSIONS
33. VON WILLEBRAND'S

Please describe any medical problems not listed here:

_____

_____

Do you have any questions for the doctor today?

_____

_____

Signature _____ Date _____ Relationship to Child _____