Berkshire Pediatric Dentistry PC

Medical History Form

Child's Name: _____ DOB: _____ Today's Date: _____

Physician's Name: _____ **Are immunizations up to date? Yes / No (circle one)**

Pharmacy Name: _____ Pharmacy Phone Number: _____

HAS YOUR **CHILD** EVER BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS? (Please answer yes/no for ALL options)

Y	N	
		ADD/ADHD (circle one)
		Anemia
		Anxiety
		Arthritis
		Asthma
		Autism Spectrum Disorder
		Bladder Conditions
		Blood Transfusions
		Birth Defects
		Bone/Orthopedic Problems
		Brain Injury
		Cancer
		Cerebral Palsy
		Child Abuse
		Chronic Adenoid/Tonsils
		Chronic Headaches/Migraine
		Chronic Ear Infections
		Cleft Lip/Palate

Y	N	
		Congenital Heart Disease
		Convulsions/Seizures
		Diabetes
		Emotional Disturbances
		Epilepsy
		Eye Problems
		Excessive Gagging
		Fainting/Dizziness
		Growth/Development Issue
		Handicap/Disability
		Hearing/Speech Problems
		HIV/AIDS
		Heart Murmur/Defects
		Hemophilia/Excess Bleeding
		Hepatitis or Liver Disease
		Intellectual Disability
		Kidney Disease
		Leukemia

Y	N	
		Malignant Hyperthermia
		Nutritional Deficiency
		Pacemaker
		Pregnancy
		Premature Birth
		Psychiatric Issues/Treatment
		Reflux/Stomach Problems
		Respiratory Problems
		Rheumatic Fever
		Scoliosis
		Sensory Disorder
		Sickle Cell Anemia
		Sinus Problems
		Stroke
		Syndrome:
		Tuberculosis
		Tumors
		Ulcers

Other:

Surgeries (date and type):

Please list all **medications** _____

Allergies? Yes / No *If yes, please circle:* Local Anesthetic Penicillin/Amoxicillin Sulfa Latex Peanuts Tree Nuts

Other: _____

Parent's Signature _____ Doctor's Signature _____

Date _____ Date _____