sprout
PEDIATRIC DENTISTRY
& ORTHODONTICS

Patient Medical Health History

Patient Name: _____ Date of Birth: _____

Patient's Pediatrician/Physician: _____ Practice Name: _____

Current medications: □ None □ List: _____

Allergies (food/drug/latex): □ None □ List: _____

Has the patient ever had any of the following conditions?

□ Anxiety / Depression	□ Cerebral Palsy	□ Intellectual Disability
□ Asthma	□ Congenital Birth Defects	□ Kidney Problems
□ Abnormal Bleeding/Bruising	□ Congenital Heart Defects	□ Organ transplant
□ Acid Reflux / GI Problems	□ Diabetes	□ Any Operations
□ ADD / ADHD	□ Eating Disorder	□ Physical Disability
□ Artificial Joints or Heart Valves	□ Fainting spells	□ Seizures/Epilepsy
□ Autism / ASD	□ Hearing Impairment	□ Sickle Cell Anemia
□ Autoimmune Disease	□ High / low blood pressure	□ Snoring/Sleep Apnea
□ Blood Disorders	□ Hepatitis/Liver Conditions	□ Tonsils/Adenoids removed
□ Cancer	□ HIV/AIDS	□ Tuberculosis

Please elaborate on any of the above or list any other health problems/special concerns: _____

_____

Patient Dental History

Previous Dentist/Office Name (if applicable): _____

Is the patient taking supplemental fluoride tablets/drops? Y N

Has your child been evaluated by an orthodontist? Y N With whom: _____

Additional comments regarding your child's dental history: _____

_____

I have read and understand the above questions and have answered them to the best of my ability. If there are any changes to the patient's health status, I will inform the dentist and staff.

Parent/Guardian Signature: _____ Date: _____

Print name: _____

Doctor Signature: _____ Date: _____