BELLGRADE DENTAL CENTER

MINOR HEALTH HISTORY

NAME _____ **DATE** _____

DATE OF BIRTH _____

PHARMACY

PHARMACY NAME _____ **PHONE #** (___)_____

ALLERGIES

(INCLUDING LATEX)
OR NONE

_____

MEDICATIONS

(LIST ALL MEDICATIONS OR PURPOSE)
OR NONE

_____

Are you taking meds for OSTEOPOROSIS? _____
Including FOSAMAX / ACTONEL / BONIVA? _____

MEDICAL HISTORY (CHECK THOSE THAT APPLY)

WELL WATER/BOTTLED WATER___
HEART VALVE DISEASE (MURMUR) ___
HEART ARTERY DISEASE ___
HIGH BLOOD PRESSURE ___
CIRCULATORY PROBLEMS ___
NERVOUS PROBLEMS ___
CHEMO/RADIATION TREATMENT ___
ARTIFICAL HEART VALVE ___
RHEUMATIC FEVER ___
THUMB SUCKING___
COLD SORES/FEVER BLISTERS___
TUBERCULOSIS ___
HEADACHES ___
HEPATITUS ___
CANCER ___
ULCER ___
HIV/AIDS ___
SCARLET FEVER ___
CHEMICAL DEPENDENCY ___
CANKER SORES/MOUTH ULCERS___
CURRENTLY NURSING ___
HEMOPHILIA ___
STROKE ___
ASTHMA ___
DIABETES ___
BACK PROBLEMS __
ARTHRITIS ___

HAVE YOU EVER HAD AN ADVERSE REACTION TO DENTAL TREATMENT OR ANESTHICS? IF YES, PLEASE EXPLAIN. _____

HAS THE MINOR EVER HAD SPEECH OR EATING DIFFICULTIES? _____

DOES THIS CHILD USE ANY TOBACCO PRODUCTS ? WHICH ONES? _____

DOES YOUR CHILD USE ANY ALCOHOL OR CONTROLLED SUBSTANCES? _____

PHYSICIAN NAME _____ **PHYSICIAN #** _____