NAME: Birth Date:

MEDICAL HISTORY(child)

Has your child any history of or difficulty with any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Latex Allergy	☐	☐	HIV positive	☐	☐	Blood Disorder
☐	☐	Cardiovascular Disease	☐	☐	Autoimmune Disorder	☐	☐	Liver Disease
☐	☐	Heart Murmur	☐	☐	Kidney Trouble	☐	☐	Neurologic Disorder
☐	☐	Congenital Heart Lesions	☐	☐	Environmental Allergies	☐	☐	Seizures
☐	☐	Hyperactivity	☐	☐	Food Allergies	☐	☐	Diabetes
☐	☐	ADHD	☐	☐	Sinus Trouble	☐	☐	Arthritis
☐	☐	Autism Spectrum	☐	☐	Asthma	☐	☐	Tuberculosis
☐	☐	Sensory Disorders	☐	☐	Cancer	☐	☐	Other

Was your child's birth premature? Yes ☐ No ☐ How early? _____

Has your child ever experienced excessive bleeding? Yes ☐ No ☐

If yes, please explain: _____

Has your child ever had surgery, radiation therapy, or been hospitalized? Yes ☐ No ☐

Purpose: _____

Does your child have any mental ☐ Emotional ☐ Physical ☐ limitations? _____

Is your child taking medications? Yes ☐ No ☐ If yes, what? _____

Does your child take fluoride in any form? Yes ☐ No ☐

Has your child ever experienced an allergic reaction to any medications or substances? Yes ☐ No ☐

If yes, what? _____

Name of Pediatrician/Physician _____

Location or Address: _____

_____

Does your child have any medical condition not listed above? Yes ☐ No ☐

If yes, please explain: _____

_____

Is this your child's first visit to any dentist? Yes ☐ No ☐ Date of last visit? _____

Does any of the following apply to your child?

- ☐ Injury to mouth or teeth
- ☐ Unhappy dental experiences
- ☐ Tooth ache
- ☐ Prolonged pacifier, thumb or finger sucking
- ☐ Currently bottle fed
- ☐ Mouth breather
- ☐ Ear Infections
- ☐ Unusual speech habits
- ☐ Previous orthodontia

Does your child have any current dental complaints Yes ☐ No ☐

If yes, what? _____

Previous Dentist: _____

Please mention any special needs or additional information that might improve our understanding of your child.

_____

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for the comfort and well being of my child.

Date: _____ Signature of parent or guardian; _____ Doctor's initials: _____

Patrice Espinosa, D.D.S.

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