# Bragg Creek Dental

## CHILD MEDICAL HISTORY

Date:_____ Patient Name:_____

Birth date (day/month/year)_____ Male Female

Name of person completing this form:_____

Retalationship to patient: Parent Guardian Other_____

Mother's Name:_____ Father's Name:_____

Home address:_____ City:_____

Prov:_____ Postal Code:_____ Phone numbers:_____

Email address:_____

Child's Alberta Health Care#:_____ Physician:_____

Who is financially responsible for this account?_____

### Medical History

Is your child in good health? Y / N Date of last medical exam_____
Has your child ever had a health problem?_____
Is your child allergic to anything?_____
Is your child currently taking any medications? Y/N If yes, please provide medication, dose and reason:_____
Are your child's immunizations current? Y / N
Have you ever been told that your child needs to take antibiotics before dental treatment? Y /N
Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Y /N
Were there any dificulties at birth or pre mature? Y / N _____

Please circle if the patient have or has ever had the following:

| | | | |
|---|---|---|---|
| Arthritis | Emotional Disability | Brain Injury | Orthopedic Problems |
| Asthma | Learning Disability | Cerebral Palsy | Cancer |
| Diabetes | Behavior Issues | Cleft lip/palate | Leukemia |
| GI Disorders | Psychiatric Disorder | Developmental Delay | Fainting/headaches |
| Heart Disease | Hepatitis | Eating Problems | Gag reflex |
| Kidney Disease | HIV infection | Growth Problems | Sleep Apnea |
| Rheumatic Fever | Tuberculosis | Seizures | Sleep Problems |
| ADHD | Anemia | Speech Problems | Snoring |
| Anxiety/Nervousness | Bleeding (prolonged) | Hearing Loss | Other (specify): |
| Autism | Hemophilia | Neuromuscular Defect | _____ |