



Growth and Development

Any learning, behavioral, excessive nervousness, or communication problems? Yes No
Psychological counseling in the past or being considered in the near future? Yes No
History of problems with physical growth? Yes No

Central nervous system

History of Cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? Yes No
History of injury to the head or face? Yes No
Sensory disorders: hearing or vision problems? Yes No

Cardiovascular system

History of congenital heart disease, heart murmur, or heart damage from rheumatic fever? Yes No
Has the patient been recommended or undergone any heart surgery? Yes No
Any History of chest pains or high blood pressure? Yes No

Hematopoietic and lymphatic system

Ever received a blood transfusion or blood products transfusion? Yes No
History of anemia or sickle cell disease? Yes No
Bruise easily, have frequent nose bleeds, or bleed excessively from small cuts? Yes No
More susceptible to infections than normal? Yes No
History of tender or swollen lymph nodes or glands? Yes No

Respiratory system

History of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty breathing? Yes No

Gastrointestinal system

History of stomach, intestinal or liver problems? Yes No
History of eating disorders such as anorexia nervosa or bulimia? Yes No
History of hepatitis or jaundice? Yes No
History of unintentional weight loss? Yes No

Genitourinary system

History of urinary tract infections, bladder or kidney problems? Yes No
Is the patient pregnant or possibly pregnant? Yes No

Endocrine system

History of diabetes? Yes No
History of thyroid disorders or other glandular disorders? Yes No

Skin

History of skin problems, cold sores, or canker sores (apthae)? Yes No

Allergies

History hay fever, hives, or skin rashes? Yes No
Is the patient known to be allergic to latex? Yes No

Extremities

Limitations of use of arms or legs? Yes No
History of arthritis, joint bleeding, joints replacements, or other joint problems? Yes No
History of problems with muscle weakness or muscular dystrophy? Yes No

Has a doctor ever recommended that the patient take antibiotics prior to dental procedures? Yes No

Does the patient need to take antibiotics before dental procedures for any reason? Yes No

Please list all medications which the patient is currently taking or any medications which the patient takes occasionally including over the counter medications such as aspirin:

Please list all medical conditions, problems, or diseases:

I have answered the questions on this form to the best of my knowledge as of the date indicated:

Signature of Responsible Party _____

Date _____