UCSF Benioff Children's Hospital
San Francisco

Patient name (Last, First): ____________________________________________ Patient Birthdate: ______________________

Guardian name (Last, First): ___________________________________________ Relation: ____________________________

**Medical History**

| Question | | |
|---|---|---|
| Are there any health conditions that necessitate taking medication prior to your child's dental treatment? | □ Y | □ N |
| Is he/she taking any type of medication, vitamins, or herbal supplements? (If so, please list) | □ Y | □ N |

Is he/she allergic to any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Any kind of medications | □ Y | □ N | Latex | □ Y | □ N | Other: | □ Y | □ N |
| Please List: | | | Metals or acrylic | □ Y | □ N | Please list: | | |
| | | | Food | □ Y | □ N | | | |

| | | |
|---|---|---|
| Has your child ever been hospitalized, had a serious illness/injury, or had any surgeries? | □ Y | □ N |
| Reason and Date: | | |

Does your child have any history of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **At birth** | | | **Musculoskeletal** | | | **Oncological** | | |
| Born premature | □ Y | □ N | Arthritis | □ Y | □ N | Cancer or malignancy | □ Y | □ N |
| Congenital abnormalities or inherited disorders | □ Y | □ N | Bone or joint problems | □ Y | □ N | Radiation or chemotherapy | □ Y | □ N |
| Cleft lip/palate | □ Y | □ N | Muscle weakness | □ Y | □ N | Other | □ Y | □ N |
| Other | □ Y | □ N | Other | □ Y | □ N | **Infectious disease** | | |
| **Cardiovascular** | | | **Dermatological** | | | Measles, mumps, chicken pox | □ Y | □ N |
| Congenital heart defect | □ Y | □ N | Eczema | □ Y | □ N | Tuberculosis | □ Y | □ N |
| Heart murmur | □ Y | □ N | Rash or hives | □ Y | □ N | Mononucleosis | □ Y | □ N |
| Rheumatic fever | □ Y | □ N | Other: | □ Y | □ N | Hepatitis | □ Y | □ N |
| Other: | □ Y | □ N | **Neurological** | | | Other: | □ Y | □ N |
| **Respiratory** | | | Fainting or dizziness | □ Y | □ N | **Auditory and Visual** | | |
| Asthma or reactive airway disease | □ Y | □ N | Convulsions or seizures | □ Y | □ N | Chronic ear infections | □ Y | □ N |
| Upper respiratory infections | □ Y | □ N | Hydrocephaly | □ Y | □ N | Hearing impairments | □ Y | □ N |
| Snoring or apnea | □ Y | □ N | Cerebral Palsy | □ Y | □ N | Visual problems | □ Y | □ N |
| Other: | □ Y | □ N | Mental disability | □ Y | □ N | Other: | □ Y | □ N |
| **Gastrointestinal** | | | Other: | □ Y | □ N | **Behavioral** | | |
| Metabolism abnormalities | □ Y | □ N | **Endocrine** | | | Developmental delay | □ Y | □ N |
| Gastro esophageal reflux disease | □ Y | □ N | Diabetes | □ Y | □ N | Autism | □ Y | □ N |
| Ulcers | □ Y | □ N | Thyroid problems | □ Y | □ N | ADHD/hyperactivity | □ Y | □ N |
| Eating disorders | □ Y | □ N | Growth delays | □ Y | □ N | Traumatic stress disorder | □ Y | □ N |
| Liver disease | □ Y | □ N | Other: | □ Y | □ N | Alcohol or chemical dependency | □ Y | □ N |
| Other: | □ Y | □ N | **Hematological/immunologic** | | | Psychiatric treatment | □ Y | □ N |
| | | | Excessive bleeding or bruising easily | □ Y | □ N | Other: | □ Y | □ N |
| **Genitourinary** | | | | | | | | |
| Kidney or bladder problems | □ Y | □ N | Hemophilia | □ Y | □ N | | | |
| Urinary tract infections | □ Y | □ N | Anemia | □ Y | □ N | Under the care of a specialty doctor other than their pediatrician? (If so, please list) | □ Y | □ N |
| Pregnancy | □ Y | □ N | Sickle cell disease | □ Y | □ N | | | |
| Sexually transmitted disease | □ Y | □ N | Transfusion | □ Y | □ N | | | |
| Other: | □ Y | □ N | Spleen abnormalities | □ Y | □ N | | | |
| | | | HIV/AIDS | □ Y | □ N | | | |
| | | | Other: | □ Y | □ N | | | |

**Dental History**

| | | |
|---|---|---|
| Date of last visit | | |
| Date of last dental radiographs | | |
| History of injury to teeth and jaws | □ Y | □ N |
| History of dental pain | □ Y | □ N |
| History of dental infections | □ Y | □ N |
| Does your child have any oral habits? (Finger sucking, tongue thrusting, tooth grinding, clenching, etc.) | □ Y | □ N |
| Do you anticipate cooperation problems from your child for dental appointments? | □ Y | □ N |

To my best knowledge, all of the preceding answers are true and correct. If my child ever has a change in their health history or medication, I will inform the doctor at the next appointment without fail.

Guardian Signature: ______________________________________________ Date: ___________________________