Port Pediatric Dentistry, PC

Suzanne K Port, DDS MS
291 West Lakewood Blvd Holland, MI 49424
Phone: 616-392-1100

Medical History Form

Child's Name: _____

Yes No Is your child under the care of a physician for anything other than well child check ups?

If yes, since when and why?_____

Yes No Is your child allergic to anything?_____

Yes No Is your child taking any medications including over the counter medications?

Please give medication, dose and reason _____

_____

Yes No Are your child's immunizations current?

Yes No Have you ever been told that your child needs to take an **antibiotic before having dental treatment?**

Yes No Has your child had any serious illness?

Yes No Has your child ever been hospitalized or an emergency room visit?

If yes please explain:_____

Yes No Were there any difficulties with birth?_____

Do you consider your child to be: [ ] Advanced in the learning process

[ ] Progressing normally

[ ] Slower in the learning process

Please check if your child has a history of or has been treated for any of the following:

Heart disease	Heart murmur	Bleeding/transfusions	Asthma
Anemia	Blood dyscrasias	Tonsil/adenoid problems	TB
Liver/GI disease	Sickle cell disease	Diabetes	HIV/AIDS
Kidney disease	Rheumatic fever	Hepatitis	Mental delay
Seizures	Cleft/Lip palate	Speech/hearing problems	Autism
Cerebral Palsy	Endocrine disorder	Congenital birth defects	Cancer
Physical delay	Vision problems	Adverse drug reaction	ADD/ADHD
Recurrent headache	Frequent infections	Emotional problems	Arthritis
Spina bifida	Snoring	Abuse	Other

_____ _____

Signature of Parent/Guardian Date

Comments: (*for office use only)*

_____

_____

_____

_____

_____