**CPD MEDICAL HISTORY FORM**

Patient Name:

Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_ Preferred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Pediatrician/ Primary Physician and date of last visit

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medical specialists

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Birth sex [ ]  M [ ]  F Current Gender Identity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_\_ Weight/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1**. Is your child being treated by a physician at this time? Yes [ ]  No[ ]

|  |
| --- |
| Reason?  |

**2**. Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplement? Yes [ ]  No[ ]

|  |
| --- |
| List Name , Dose, Frequency and Date started:  |

**3**. Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? Yes [ ]  No[ ]

|  |
| --- |
| List date and describe  |

**4**. Has your child ever had a reaction to or problem with an anesthetic? Yes [ ]  No[ ]

|  |
| --- |
| Describe  |

**5**. Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?

 Yes [ ]  No[ ]

|  |
| --- |
| List:  |

**6**. Is your child allergic to latex or anything else such as metals, acrylic, or dye? Yes [ ]  No[ ]

|  |
| --- |
| List:  |

**7**. Is your child up to date on immunizations against childhood disease? Yes [ ]  No[ ]

**8**. Is your child immunized against Human Papilloma Virus (HPV)? Yes [ ]  No[ ]

***~Continued on back~***

|  |  |  |
| --- | --- | --- |
| Please mark YES if your child has a history of the following conditions. *For each "YES", provide details in the box at the bottom of this list*. Mark NO after each line if none of those conditions applies to your child. | **YES** | **NO** |
| 9 | Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions  |  |  |
| 10 | Problems with physical growth or development  |  |  |
| 11 | Sinusitis, chronic adenoid/tonsil infections  |  |  |
| 12 | Sleep apnea/snoring, mouth breathing, or excessive gagging  |  |  |
| 13 | Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease  |  |  |
| 14 | Irregular heart beat or high blood pressure  |  |  |
| 15 | Asthma, reactive airway disease, wheezing, or breathing problems  |  |  |
| 16 | Cystic Fibrosis  |  |  |
| 17 | Frequent colds or coughs, or pneumonia  |  |  |
| 18 | Frequent exposure to tobacco smoke  |  |  |
| 19 | Jaundice, hepatitis, or liver problems  |  |  |
| 20 | Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems  |  |  |
| 21 | Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions  |  |  |
| 22 | Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder  |  |  |
| 23 | Bladder or kidney problems  |  |  |
| 24 | Arthritis, Scoliosis, limited use of arms or legs, or muscle/bone/joint problems  |  |  |
| 25 | Rash/hives, Eczema or skin problems/Rash  |  |  |
| 26 | Impaired vision, hearing, or speech  |  |  |
| 27 | Developmental disorders, learning problems/delays, or intellectual disability  |  |  |
| 28 | Cerebral Palsy, brain injury, epilepsy, or convulsions/seizures  |  |  |
| 29 | Autism or autism spectrum disorder  |  |  |
| 30 | Recurrent or frequent headaches/migraines, fainting, or dizziness  |  |  |
| 31 | Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial,ventriculovenous  |  |  |
| 32 | Attention Deficit/Hyperactivity Disorder (ADD/ADHD)  |  |  |
| 33 | Behavioral, emotional, communication, or psychiatric problems, treatment  |  |  |
| 34 | History of abuse (physical, psychological, emotional, or sexual) or neglect  |  |  |
| 35 | Diabetes, hyperglycemia, or hypoglycemia  |  |  |
| 36 | Precocious puberty or hormonal problems  |  |  |
| 37 | Thyroid or pituitary problems  |  |  |
| 38 | Anemia, sickle cell disease/trait, or blood disorder  |  |  |
| 39 | Hemophilia, bruising easily, or excessive bleeding  |  |  |
| 40 | Transfusions or receiving blood products  |  |  |
| 41 | Cancer, tumor, other malignancy, chemotherapy, radiation therapy, bone marrow or organ transplant  |  |  |
| 42 | Mononucleosis, Tuberculosis (TB), Scarlet Fever, Cytomegalovirus (CMV), Methicillin Resistant Staphylococcus Aureus (MRSA), sexually transmitted disease (STD), or Human Immunodeficiency Virus (HIV)/AIDS  |  |  |
| 43 | Is there any other significant medical history pertaining to this child or his/her/their family that the dentist should be told?  |  |  |
| 44 | **Provide Details Here**  |

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