George M. Wilson D.D.S., Inc 380 W. Putnam Ave., Porterville, CA 93257 (559) 781-9117 (2/11/14)

Child's Name: _____

Physician's Name: _____

1. Does your child have a fever at this time?. . . . . Yes No
2. Does your child have a bronchitis? . . . . . .Yes No
3. Does your child have an unexplained rash?. . . . . Yes No
4. Date of last physical exam: _____
5. Is your child currently under medical care?. . . . . Yes No
   If so, explain: _____
6. Is he or she taking any of the following?
   a. Antibiotics or sulfa drugs . . . . . Yes No
   b. Anticoagulants (blood thinners) . . . . . Yes No
   c. Aspirin . . . . . Yes No
   d. Bisphosphonate . . . . . Yes No
   e. Dilantin or other anticonvulsant . . . . . Yes No
   f. Fen-Phen or Redux . . . . . Yes No
   g. Insulin . . . . . Yes No
   h. Medicine for high blood pressure . . . . . Yes No
   i. Steroids or Cortisone . . . . . Yes No
   j. Other medication: _____ Yes No
7. Is your child allergic or ever reacted adversely to?
   a. Aspirin . . . . . Yes No
   b. Latex . . . . . Yes No
   c. Local anesthetics . . . . . Yes No
   d. Penicillin or other antibiotic . . . . . Yes No
   e. Sulfa drugs . . . . . Yes No
   f. Other: _____ Yes No
8. Has your child had or have any of these medical problems?
   a. Asthma or Hay fever?. . . . . Yes No
   b. Cardiovascular (Murmur, coronary occlusion high blood pressure, arteriosclerosis, stroke . . Yes No
   c. Cerebral palsy . . . . . Yes No
   d. Cleft lip/palate . . . . . Yes No
   e. Congenital heart disease . . . . . Yes No
   f. Developmental disability . . . . . Yes No
      If so explain: _____
   g. Diabetes . . . . . Yes No
   h. Emphysema . . . . . Yes No
   i. Epilepsy, seizures, or fainting spells . . . . . Yes No
   j. Hearing or speech disability . . . . . Yes No
   k. Hemophilia (abnormal bleeder) . . . . . Yes No
   l. Inflammatory rheumatism / Arthritis . . . . . Yes No
   m. Kidney problems . . . . . Yes No
   n. Liver disease, Jaundice. . . . . Yes No
   o. Mental retardation . . . . . Yes No
   p. Rheumatic fever or rheumatic heart disease. . Yes No
   q. Sickle Cell disease . . . . . Yes No
   r. Stomach ulcers . . . . . Yes No
   s. Thyroid disease . . . . . Yes No
   t. Other . . . . . Yes No
      If so explain: _____
9. Was your child a patient in a hospital for a serious illness or operation? . . . . . Yes No
   If so, explain: _____
10. Was your child premature? . . . . . Yes No
11. Has your child lost 5 or more pounds in the last six months without dieting? . . . . . Yes No
12. Does your child have night sweats or fatigue . . . . . Yes No
13. Is your child vomiting or suffering from diarrhea . . . . .Yes No
14. Does your child have a stiff neck? . . . . . .Yes No
15. Has your child ever required a blood transfusion? . . . . . Yes No
    If so when: _____
16. Has your child ever tested positive for, or has been diagnosed as having any of the following diseases:
    a. Aids . . . . . Yes No
    .b. Hepatitis A . . . . . .Yes No
    c. Hepatitis B . . . . . Yes No
    d. Herpes . . . . . Yes No
    e. Mononucleosis . . . . . Yes No
    f. NANB hepatitis, Delta hepatitis. . . . . Yes No
17. Does your child have or been exposed to anyone with one of the following aerosol transmissible illness listed?
    a. Any flu other than seasonal flu . . . . . Yes No
    b. Chickenpox . . . . . Yes No
    c. Diphtheria . . . . . Yes No
    d. Epstein-Bar Virus . . . . . Yes No
    e. Measles . . . . . Yes No
    f. Meningitis . . . . . Yes No
    g. Monkeypox . . . . . Yes No
    h. Mumps . . . . . Yes No
    i. Parvovirus . . . . . Yes No
    j. Pertussis (whooping cough) persistent or blood . . . . Yes No
    k. Pharyngitis . . . . . Yes No
    l. Pneumonia . . . . . Yes No
    m. SARS . . . . . Yes No
    n. Scarlet Fever . . . . . Yes No
    o. Shingles . . . . . Yes No
    p. Smallpox . . . . . Yes No
    q. Strep . . . . . Yes No
    r. Tuberculosis . . . . . Yes No

Dental History (questions 13-22)

13. Name of previous dentist: _____
14. Date of last dental examination: _____
15. Has your child had any serious trouble associated with any previous dental treatment? . . . . . Yes No
16. Do his/her gums bleed when brushing teeth? . . . . . Yes No
17. Does he/she have a toothache? . . . . . Yes No
    Area_____
18. Does he/she grind or clench teeth? . . . . . Yes No
19. Has he/she had any injuries to the jaw, mouth or teeth? Yes No
    Area_____
20. Does your child have any sores in the mouth or on any other parts of the body at this time? . . . . . .Yes No
21. Does your child have a disability that prevents treatment in the dental office? . . . . . .Yes No
    If so explain: _____
22. Has he/she ever had orthodontic treatment? . . . . . Yes No

These questions apply to the adolescent woman (teens)

26. Are you pregnant now, or think you may be? . . . . . Yes No
27. Are you taking the pill? . . . . . Yes No

Additional comments regarding your child's health not covered above: _____

To the best of my knowledge, all the preceding answers are true and correct. If my child ever has a change in his/ her health or his/her medicines change, I will inform the dentist at the next appointment without fail. I hereby authorize those all-necessary dental services required for a dental examination including diagnostic aids such as models, photos, and x-rays be rendered. A prophylaxis is also authorized when deemed necessary. (Other more extensive dental treatment will be discussed with you prior to treating).

Parent or Legal Guardian signature _____ **Date:** _____

Child's Name: _____ **Child's Birthdate:** _____

Section 1: MEDICAL HISTORY UPDATE: I the parent/legal guardian have reviewed the health history, and listed any changes below.

Has there been any change in your child's health since the last dental appointment? Yes No
Is your child taking any kind of medication at this time? Yes No
Has your child had any allergies or adverse reactions to any medication? Yes No
Please any questions marked yes and/or give any additional information you feel pertinent: _____
List any hospitalizations and reason: _____
Who brought child today? _____
Parent or Legal Guardian signature _____ **Date:** _____

Staff notes: _____

Section 2: MEDICAL HISTORY UPDATE: I the parent/legal guardian have reviewed the health history, and listed any changes below.

Has there been any change in your child's health since the last dental appointment? Yes No
Is your child taking any kind of medication at this time? Yes No
Has your child had any allergies or adverse reactions to any medication? Yes No
Please any questions marked yes and/or give any additional information you feel pertinent: _____
List any hospitalizations and reason: _____
Who brought child today? _____
Parent or Legal Guardian signature _____ **Date:** _____

Staff notes: _____

Section 3: MEDICAL HISTORY UPDATE: I the parent/legal guardian have reviewed the health history, and listed any changes below.

Has there been any change in your child's health since the last dental appointment? Yes No
Is your child taking any kind of medication at this time? Yes No
Has your child had any allergies or adverse reactions to any medication? Yes No
Please any questions marked yes and/or give any additional information you feel pertinent: _____
List any hospitalizations and reason: _____
Who brought child today? _____
Parent or Legal Guardian signature _____ **Date:** _____

Staff notes: _____

Section 4: MEDICAL HISTORY UPDATE: I the parent/legal guardian have reviewed the health history, and listed any changes below.

Has there been any change in your child's health since the last dental appointment? Yes No
Is your child taking any kind of medication at this time? Yes No
Has your child had any allergies or adverse reactions to any medication? Yes No
Please any questions marked yes and/or give any additional information you feel pertinent: _____
List any hospitalizations and reason: _____
Who brought child today? _____
Parent or Legal Guardian signature _____ **Date:** _____

Staff notes: _____

Section 5: MEDICAL HISTORY UPDATE: I the parent/legal guardian have reviewed the health history, and listed any changes below.

Has there been any change in your child's health since the last dental appointment? Yes No
Is your child taking any kind of medication at this time? Yes No
Has your child had any allergies or adverse reactions to any medication? Yes No
Please any questions marked yes and/or give any additional information you feel pertinent: _____
List any hospitalizations and reason: _____
Who brought child today? _____
Parent or Legal Guardian signature _____ **Date:** _____

Staff notes: _____