BOTHELL PEDIATRIC DENTISTRY
SPECIALISTS IN INFANTS, CHILDREN & ADOLESCENTS

PATIENT MEDICAL/DENTAL HISTORY

Name _____ Nickname _____ Date of Birth _____ Boy/Girl

Brothers, Sisters _____

MEDICAL INFORMATION

Child's Physician _____ Phone # _____

Is your child taking any medications? Y / N Please list _____

_____

Does your child have any allergies or drug sensitivities? _____ Please describe _____

_____

Please check any of the following conditions for which your child has been treated

- □ Asthma or Airway/Lung Issues
- □ Autism
- □ Bleeding Disorder/Anemia
- □ Behavioral Diagnosis (i.e. ADD/ADHD)
- □ Cancer or any other tumor
- □ Cerebral Palsy
- □ Developmental Delay
- □ Diabetes
- □ Epilepsy/Seizures
- □ GERD/Nutritional Concerns
- □ Genetic Concerns (i.e. MTHFR gene mutation)
- □ Heart Disorder/Defect or Murmur
- □ Hepatitis
- □ Liver/Kidney Disorders
- □ Speech/Hearing/Vision Problems
- □ Other

Please describe _____

Has your child ever been hospitalized or required surgery? Y / N Please describe _____

DENTAL INFORMATION

Parent's Dentist _____ Phone # _____

Please describe your main concern about your child's dental health _____

_____

Has your child had a negative experience in the past with a dentist or physician? _____ Please explain _____

_____

SIGNATURE _____ Relationship with Child _____

Date _____