

MEDICAL HISTORY: Please indicate if you (referring to patient) have or have had any of the following:

Yes		No		Yes		No		Yes		No	
Heart Disease		Sinusitis, Hay Fever		Special Diets		Blood Disease					
Asthma		Tuberculosis		Rheumatic Fever		Cancer					
Chronic Cough		Epilepsy		Heart Murmur		Cleft Lip/Palate					
High Blood Pressure		Nervous Disorder		Scarlet Fever		Colic					
Kidney Trouble		Thyroid Disorder		Frequent Colds		Liver Disease					
Stomach Disorder		Hyperactivity		Immune Deficiency		Hepatitis					
Diabetes		Bleeding Disorder		Shortness of Breath		Anemia					
Sickle Cell Disease		Psychiatric Treatment		Fever Blisters		Heart Trouble					

To the best of your knowledge, have you been exposed to the AIDS virus? Yes No

Are you allergic to:

Yes		No		Yes		No		Yes		No	
Aspirin		Codine		Local Anesthetic		Penicillin					
Other Antibiotics		Any other allergies to medications or substances?									

If yes, please list: _____

List current medications: _____

Pediatrician: _____ Phone No: _____

Yes No

<input type="checkbox"/>	Has your child ever been hospitalized?
<input type="checkbox"/>	Was your pregnancy full term?
<input type="checkbox"/>	Did your child go home with you from the hospital?
<input type="checkbox"/>	Were there complications during or after pregnancy?
<input type="checkbox"/>	Has there been any concern by your Pediatrician about your child's development?
<input type="checkbox"/>	Are you happy with the way your child is growing?
<input type="checkbox"/>	Do any family members or close relatives have significant medical problems?
<input type="checkbox"/>	If yes, _____
<input type="checkbox"/>	Does your child have any disease, condition, or problem not listed above?
<input type="checkbox"/>	If yes, _____



DENTAL HISTORY

Do you feel your child will need braces? _____

Have other family members had braces? _____ If yes, who? _____

Have your child's tonsils been removed? _____ Adenoids? _____ When? _____

Does your child:

Yes		No		Yes		No	
<input type="checkbox"/>	prefer breathing through mouth than nose?	<input type="checkbox"/>	have "finger habits" (sucking thumb)?	<input type="checkbox"/>	chew gum?	<input type="checkbox"/>	chew on ice?
<input type="checkbox"/>	have frequent headaches?	<input type="checkbox"/>	bite their nails?				
<input type="checkbox"/>	have click or pop when opening jaw?						
<input type="checkbox"/>	have pain in jaw when chewing?						



CONSENT:

The undersigned hereby authorizes Michael P. Healey, D.D.S., P.C. to take radiographs, diagnostic models, photographs, or any other diagnostic aids deemed appropriate by Dr. Healey to perform a thorough diagnosis.

Patient: _____ Date: _____

Patient or responsible party: _____ Relationship to patient: _____

DOCTOR'S SUMMARY: _____
