Medical History Review

Age_____

Child's Name_____
Parent's Name_____
Address_____
City_____State_____Zip_____
Home Phone_____
Mother's Employer_____Phone_____
Father's Employer_____Phone_____

Please answer the following questions for us by circling the appropriate answer.

1. Has your child seen a medical doctor for anything unusual or serious within the last six months?_____Yes / No
2. Is your child currently under the care and treatment of a medical doctor for any sickness?_____Yes /No
3. Is your child currently taking any medications prescribed by a dentist or medical doctor?_____Yes / No
4. Does your child have any type of seizure disorder, heart problems, blood problem, or allergy?_____Yes/ No
5. Questions you have for the Dr.?_____
   _____
   _____

Date_____Parent Signature_____

FOR OFFICE USE BELOW THIS LINE

Present Medical Status Positive/Negative

Dr.'s Initials_____