Medical History Update

Kind Kids DENTAL

PATIENT NAME _____ **DATE OF BIRTH** _____

Gender: ☐ Male ☐ Female ☐ Other Preferred pronouns _____

Has there been a recent change in address in the past 6 months or since your last visit? ☐ Yes ☐ No

Has there been a recent change in insurance in the past 6 months or since your last visit? ☐ Yes ☐ No

Has your child ever had any of the following medical conditions?

☐ *Pre-Med - Amox	☐ Cancer	☐ Nervous Disorders
☐ *Pre-Med - Clind	☐ Diabetes	☐ Pacemaker
☐ *Pre-Med - Other	☐ Down Syndrome	☐ Pregnancy
☐ ADHD	☐ Epilepsy	☐ Premature Birth
☐ Allergy - Allergies	☐ Excessive bleeding	☐ Radiation Treatment
☐ Allergy - Aspirin	☐ Fainting	☐ Respiratory Problems
☐ Allergy - Codeine	☐ Glaucoma	☐ Rheumatic Fever
☐ Allergy - Erythro	☐ Head injuries	☐ Rheumatism
☐ Allergy - Hay Fever	☐ Heart disease	☐ Sensory/On Spectrum
☐ Allergy - Latex	☐ Heart murmur	☐ Sinus Problems
☐ Allergy - Other	☐ Hepatitis	☐ Special Needs NOS
☐ Allergy - enn/Amox	☐ High blood pressure	☐ Stomach Problems
☐ Allergy - Sulfa	☐ HIV	☐ Stroke
☐ Anemia	☐ Jaundice	☐ Tuberculosis
☐ Asthma	☐ Kidney Disease	☐ Tumors
☐ Autism	☐ Liver Disease	☐ Ulcers
☐ Blood Disease	☐ Mental disorders	

Does your child have any other health problems or new diagnoses? ☐ Yes ☐ No

Is your child taking any new medications or supplements at this time? ☐ Yes ☐ No

Has your child had any recent surgeries, medical issues, or hospitalizations since your last visit? ☐ Yes ☐ No

Is your child under care of the same pediatrician? ☐ Yes ☐ No

Do you have any new dental, airway, or sleep concerns? ☐ Yes ☐ No

Please read and acknowledge by checking the box:

☐ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature Date

_____ _____

Relationship to patient Name if not the patient