

Pediatric Dental Associates  
1 Pomperaug Office Park  
Southbury, CT 06488

Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Date: \_\_\_\_\_

### MEDICAL HISTORY QUESTIONNAIRE

1. Does the patient have any health problems? yes no  
If yes, explain \_\_\_\_\_
2. Is the patient currently seeing a physician for any problem? yes no  
If yes, explain \_\_\_\_\_
3. Did the patient have any health problems or illnesses when younger or at birth? yes no  
If yes, explain \_\_\_\_\_
4. Does the patient take any medications? yes no  
If yes, explain \_\_\_\_\_
5. Has the patient had any allergic or bad reactions to foods or medicines? yes no  
If yes, explain \_\_\_\_\_
6. Has the patient ever been injured or stayed in the hospital overnight? yes no  
If yes, explain \_\_\_\_\_
7. Is the patient pregnant or has she been pregnant in the past? yes no  
Is the patient taking a contraceptive pill? yes no
8. Has the patient ever had a blood transfusion? yes no
9. Has the patient ever had any of the following?
  - Blood problems such as sickle cell anemia..... yes no
  - Easy bleeding or bruising..... yes no
  - Seizures or fainting spells..... yes no
  - Frequent headaches..... yes no
  - Heart murmur, heart defect or rheumatic fever..... yes no
  - Breathing problems or asthma..... yes no
  - Frequent cough or tuberculosis (TB)..... yes no
  - Hepatitis or liver problems..... yes no
  - Stomach or bowel problems..... yes no
  - Diabetes (sugar), endocrine or hormone problems..... yes no
  - Kidney problems..... yes no
  - Hives or skin rash..... yes no
  - AIDS or HIV infection..... yes no
  - Venereal disease..... yes no
  - Birth defect or disability..... yes no
10. Does the patient have any behavior or learning problems? yes no  
What grade at school is the patient in? \_\_\_\_\_
11. Who takes care of the patient at home? \_\_\_\_\_
12. Has the patient had any disease, condition or problem not listed above? yes no  
If yes, explain \_\_\_\_\_
13. Name of patient's pediatrician or family physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Date of last physical examination \_\_\_\_\_

**TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date