CHERYL M. LEE, DDS, MS

PEDIATRIC & ADOLESCENT DENTISTRY

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PATIENT NAME:_____

MEDICAL INFORMATION

Child's pediatrician_____ Phone_____

Date of last physical examination _____ Is your child under a doctor's care other than annual physical exam?_____

For what reason? _____

Is your child taking any medication or drugs? _____What kind? _____

For what reason? _____

Has your child ever been hospitalized? _____ When? _____

For what reason? _____

Is your child allergic to any medications? _____ What kind? _____

Describe the reaction _____

Does your child have an allergic reaction to food? _____ latex? _____ Seasonal allergy?_____

Are you child's immunizations up-to-date? _____

Has your child had a history or difficulty with any of the followings:

YES	NO		YES	NO		YES	NO	
____	____	Allergies to Medication	____	____	Autism Spectrum Disorder	____	____	Sickle Cell Anemia
____	____	Heart Murmur / Heart Problems	____	____	Hyperactivity / ADHD	____	____	Autoimmune Disease
____	____	Bleeding Disorder	____	____	Clinical Depression	____	____	Liver Problems
____	____	Asthma	____	____	Sleep Apnea	____	____	Hepatitis
____	____	Other Respiratory Problems	____	____	Chronic Adenoid / Tonsils Infection	____	____	Tuberculosis
____	____	Diabetes	____	____	Chronic Ear infection	____	____	Rheumatic Fever
____	____	Other Endocrinal Problems	____	____	Hearing Difficulties	____	____	AIDS / HIV
____	____	Developmental Delay	____	____	Speech Problems	____	____	Other Immune Disorder
____	____	Mental Retardation	____	____	Cleft Lip / Cleft Palate	____	____	Cancer / Tumors
____	____	Cerebral palsy	____	____	Juvenile Rheumatoid Arthritis	____	____	Birth Defect / Syndrome
____	____	Seizure / Epilepsy	____	____	Cystic Fibrosis	____	____	Others

Comments_____

_____

_____

I guarantee the information I provided for my child's medical and dental histories was based on the best of my knowledge.

I understand that it is my responsibility to inform Dr. Lee of any changes to the information I have provided.

_____ _____ _____

Parent's/Guardian's Signature ***Print Name*** ***Date***

_____ _____

Reviewed Dentist's Signature ***Date***