Confidential Pediatric Medical Information for Dr. Paul D. Vander Kelen and Dr. Adam Pasono

Patient's Name_____ Date of Birth_____

Name of Physician/ Medical Dr._____

Please list any In-patient Hospitalizations _____
_____

Please list any reasons for which your child is currently being treated by a physician_____
_____

Please list your child's allergies--including pets, drugs and objects_____
_____

Please list any medications or pills your child is currently taking_____
_____

Does your child have or has any family member had Diabetes? Yes___ No___Who?_____

Does your child have or ever had any of the following?

Asthma	Yes ___	No ___	Heart Murmur/Rheumatic Fever	Yes ___	No ___
Tuberculosis	Yes ___	No ___	Speech or Hearing Problems	Yes ___	No ___
High/Low Blood Pressure	Yes ___	No ___	Blood Transfusions	Yes ___	No ___
Fainting Spells/Nervous Disorders	Yes ___	No ___	Epilepsy/Seizures	Yes ___	No ___
Kidney/Liver Disease	Yes ___	No ___	Hepatitis/Jaundice/AIDS	Yes ___	No ___
Arthritis	Yes ___	No ___	Cerebral Palsy	Yes ___	No ___

Please provide approximate date for any "Yes" answers above._____
_____

Radiation therapy to Head or Neck for tumor? If so where?_____

Any form of Tumor or Malignant growth? If so, where?_____

Has your child ever had heart problems or surgery? Yes__No__ What?_____

Has your child ever had abnormal bleeding from a cut or extraction? Yes__ No__

Has your child had a toothache or received a blow to his/her teeth or mouth? Yes___ No___ Where?_____

Is there a family history of congenitally missing teeth? Yes__ No__ If so, which one(s)?_____

Is your water supply fluoridated or does your child receive supplements?_____

Does your child brush at least twice a day? Yes___ No__

Does or did your child suck his thumb, fingers or pacifier past the age of 3? Yes___ No___

How do you expect your child to react in the Dental Chair? Very Good__ Good___ Poor___

In order to treat your main concern, for what reason have you made this appointment with our office? Is your child experiencing any specific dental problem(s) that you think needs immediate attention?_____
_____
_____

I attest the above statements are true. **Today's Date**_____

Parent's Signature_____