DiChristofano & DiChristofano
QUALITY DENTISTRY, COMPASSIONATE CARE

Dr. Robert DiChristofano
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Child Medical History

Patient's name _____
Last First Initial Date of Birth

Parent/guardian name _____
Physician's name _____

Questions:	Yes	No
1. Does your child have a health problem? ----------	☐	☐
2. Is your child under the care of a physician? ----------	☐	☐
If yes, please explain _____		
_____		
3. Has your child ever had a serious illness or condition? ----------	☐	☐
4. Is your child receiving any medication? ----------	☐	☐
If yes, please explain _____		
_____		
5. Is your child allergic to penicillin or any other medications? ----------	☐	☐
6. Is your child sensitive to or allergic to metals or latex? ----------	☐	☐
7. Does your child have any other allergies? ----------	☐	☐
8. Has your child ever had surgery ----------	☐	☐
9. Does your child have a heart defect or murmur? ----------	☐	☐
10. Does your child experience severe or prolonged bleeding? ----------	☐	☐
11. Does your child have AIDS or has he/she tested HIV positive? ----------	☐	☐
		☐

12. Has your child tested positive for hepatitis? ---------- ☐

13. Does your child have any learning differences? ---------- ☐ ☐

14. Does your child have any behavioral/developmental differences? ----- ☐ ☐
If so, please explain _____
_____

15. Has your child had a history of any of the following (Circle appropriate responses): diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental handicap, eyesight problems, cancer, infections, speech impediments, hearing loss, artificial heart valves, permanent shunts/drains, chemotherapy, radiation therapy, tonsillitis, leukemia, anemia, hemophilia, high or low blood pressure, artificial bones/joints/implants, tuberculosis(TB), psychological issues, fainting/seisures/ epilepsy.

16. Please list any other medical condition(s) that your child has/had:
_____
_____

I certify that the above information is complete and accurate.

Parent's signature _____ Date _____

Dentist's signature _____ Date _____