HEIM & CARROLL DMD LLC

CHILD MEDICAL HISTORY

Last Name: _____ First Name: _____ date of birth _____

Pediatrician: _____ Town: _____

ALLERGIES: ___ None, List, if any _____

Has the child had any of the following?

Congenital Heart Defect	Yes	No	Seizures	Yes	No
Breathing Problems	Yes	No	Immune Deficiency	Yes	No
Asthma	Yes	No	Cancer	Yes	No
Tuberculosis	Yes	No	Psychiatric Care	Yes	No
Diabetes	Yes	No	Depression	Yes	No
Bleeding Problems	Yes	No	Sleep Problems	Yes	No

Other illnesses: _____

Hospitalizations: _____

Medications: ___ None, list if any _____

Herbs, Vitamins, Supplements: ___ None, list if any _____

Fluoride Supplements: Yes No Do you have city (MDC) water? Yes No

Have you had your water tested for fluoride? Yes No

Do we have permission to take radiographs (dental xrays)? Yes No

Do we have permission to use fluoride? Yes No

Do you have any dental concerns about your child? _____

Parent/Guardian Signature: _____ Date _____