Time 12:03 PM | Chrystal T. Rooks, DDS, PA | Date 4/8/2025

Child Medical History(updated)

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Parent's Information

Mother's Name and Address

Father's Name and Address

Who does the child live with?

Father	◯ Yes	◯ No
Mother	◯ Yes	◯ No
Both	◯ Yes	◯ No
Legal Guardian other then parent	◯ Yes	◯ No

Medical Questions

Has your child ever been hospitalized or had surgery?	◯ Yes ◯ No	If yes	
Has your child ever been told they need antibiotics before dental treatment?	◯ Yes ◯ No	If yes	
Is your child currently taking ANY medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Has your child had any serious illness?	◯ Yes ◯ No	If yes	
Does your child have any known allergies?	◯ Yes ◯ No	If yes	

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

Abuse	◯ Yes ◯ No	Learning disability	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	ADD/ADHA	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Autism	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Bladder problems	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Bleeding disorders	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Sickle Cell Disease	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Eye Problems	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Hearing Problems	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Speech problems	◯ Yes ◯ No	Heart Problems/Murmurs	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Pregnancy	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No				

Has your child ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Guardian:

X Date:_____