NORMAN J. CEPELA, D.D.S.

DATE

NAME _____ BIRTH DATE

MEDICAL HISTORY - CHILD

PHYSICIAN'S NAME _____

Is your child taking any medication now? Yes ☐ No ☐ _____

For what purpose? _____

Has your child ever been treated for:

Heart disease	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No☐	Jaundice	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Congenital heart condition	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐

Has your child ever been treated *(other than diagnostic)* with x-ray? ..... Yes ☐ No ☐

Allergies: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐

_____

Is your child subject to prolonged bleeding or bruising? ..... Yes ☐ No ☐

Does your child have excessive urination and/or thirst? ..... Yes ☐ No ☐

Has your child been hospitalized? ..... Yes ☐ No ☐ If so, for what: _____

_____

_____

Other physical conditions: _____

_____

_____

_____

DENTAL HEALTH

Reason for visit:

Is this your child's first visit to a dentist? ..... Yes ☐ No ☐

When was your child's last dental visit? _____

Has your child ever had a problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so, explain: _____

_____

Have pit and fissure sealants been placed on any teeth? ..... Yes ☐ No ☐

Has your child had an orthodontic consultation? ..... Yes ☐ No ☐

Parent's Signature _____