The Ohio State University
COLLEGE OF DENTISTRY

College of Dentistry
Pediatric Medical History

Patient Name: ____ Today's Date: ______________________
Last *First* *MI*

Date of Birth: ______________________________

PLEASE SELECT THE CORRECT ANSWER

Y	N	GENERAL
		HEIGHT ________ FT ________ IN
		WEIGHT ________ LBS
		GENERAL HEALTH STATUS (CHOOSE ONE)
		EXCELLENT GOOD FAIR POOR
		ARE YOU UNDER PHYSICIAN'S CARE?
		HAVE YOU BEEN HOSPITALIZED IN THE PAST?
		HAVE YOU HAD ANY EMERGENCY ROOM VISITS?
		HAS YOUR DOCTOR LIMITED YOUR ACTIVITY?
		CAN YOU CLIMB TWO FLIGHTS OF STAIRS WITHOUT REST?

PLEASE ANSWER "YES" OR "NO" FOR ANY CONDITIONS THAT YOU HAVE NOW OR HAVE HAD IN THE PAST

Y	N	CARDIOVASCULAR/HEMATOLOGIC
		HEART PROBLEMS OR MURMUR
		BLEEDING OR BLOOD CLOTTING PROBLEMS
		SICKLE CELL ANEMIA OR TRAIT
Y	**N**	**PULMONARY/BREATHING**
		ALLERGIES OR HAY FEVER
		ASTHMA OR WHEEZING
		SNORING, INTERRUPTED BREATHING, SLEEP APNEA
		OTHER LUNG/BREATHING DISEASE: ______________________________
Y	**N**	**HEAD, EYES, EARS, NOSE, THROAT**
		SINUSITIS
		EAR OR HEARING PROBLEMS
		VISION PROBLEMS
Y	**N**	**NERVOUS SYSTEM**
		EPILEPSY OR SEIZURE DISORDER
Y	**N**	**GASTROINTESTINAL/LIVER**
		STOMACH OR INTESTINAL PROBLEMS
		GASTROESOPHAGEAL REFLUX
		FEEDING OR EATING PROBLEMS
		HEPATITIS OR OTHER LIVER PROBLEMS

Y	N	METABOLIC
		DIABETES
Y	**N**	**INFECTIOUS DISEASE**
		TUBERCULOSIS (TB)
		HIV POSITIVE OR AIDS
		SEXUALLY TRANSMITTED DISEASE
Y	**N**	**DEVELOPMENTAL**
		GENETIC DISORDER
		CEREBRAL PALSY
		CLEFT LIP OR PALATE
		INTELLECTUAL DISABILITY
		SPEECH PROBLEMS
		DEVELOPMENTAL DELAY
		AUTISM SPECTRUM DISORDER
		ADHD
		PREMATURITY OR PRETERM BIRTH
		RECENT RAPID GROWTH
		ONSET OF PUBERTY
		(FOR GIRLS) FIRST PERIOD Month __________ Year __________
		PREGNANT OR NURSING
		OTHER DEVELOPMENTAL OR ACQUIRED DISABILITY
Y	**N**	**SOCIAL**
		DRUG OR ALCOHOL USE
		SMOKING OR TOBACCO USE
Y	**N**	**OTHER**
		BONE OR JOINT PROBLEMS
		SKIN PROBLEMS
		KIDNEY PROBLEMS
		CANCER, CANCER TREATMENT
		ANY OTHER MEDICAL PROBLEMS ______________________________

MEDICATIONS AND ALLERGIES

LIST ANY CURRENT OR RECENT MEDICATIONS YOU TAKE:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

ALLERGIES OR REACTIONS TO ANY MEDICINES?

MEDICINE: ______________________

REACTION: ______________________

MEDICINE: ______________________

REACTION: ______________________

MEDICINE: ______________________

REACTION: ______________________

MEDICINE: ______________________

REACTION: ______________________

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my (or my child's) treatment and treatment results.