primary teeth
pediatric dentistry

Jake Fried DDS

199 S Main St
Gloversville, NY 12078
P: 518-601-2220
F: 518-601-2221
info@primaryteeth.com

Patient Medical History Form

Child's legal name: _____

Preferred name: _____ Date of birth: _____/_____/_____

Birth sex: ▢ M ▢ F Current gender identity: _____ Pronouns: _____

Race/Ethnicity: _____ Height: _____in Weight: _____lbs

Primary physician: _____

Primary physician phone: _____

Is this your child's first visit to the dentist?.....▢ YES ▢ NO

If no, was there treatment previously completed on your child's teeth?.....▢ YES ▢ NO

1. Is your child taking any medication (prescription or over the counter), vitamins or dietary supplements? If yes, please list name, dose, frequency and date started below.....▢ YES ▢ NO

2. Is your child up to date on immunizations against childhood diseases?.....▢ YES ▢ NO

3. Is your child allergic to any medications, i.e. antibiotics, sedatives or other drugs?.....▢ YES ▢ NO

If yes, please describe: _____

4. Is your child allergic to anything else, such as latex, metals, dye or specific foods?.....▢ YES ▢ NO

If yes, please describe: _____

5. Has your child ever been hospitalized, had any form of surgery, a significant injury, or been treated in an emergency department?.....▢ YES ▢ NO

If yes, please describe:_____

6. Is your child speech/hearing/visually impaired?.....▢ YES ▢ NO

If yes, please describe: _____

7. If any of the conditions listed below apply to your child please check the corresponding box.

▫ ADHD/ADD	▫ Eczema	▫ Methicillin Resistant Staphylococcus Aureus (MRSA)
▫ Anemia	▫ Epilepsy	▫ Mononucleosis
▫ Anxiety	▫ Excessive Bleeding	▫ Mouth Breathing
▫ Arthritis	▫ Excessive Gagging	▫ Muscle/Joint/ Bone Problems
▫ Asthma	▫ Fainting/ Dizziness	▫ Nutritional Deficiencies
▫ Autism	▫ Fine/Gross Motor Deficit	▫ Obesity
▫ Bladder/Kidney Problems	▫ Frequent Headaches/ Migraines	▫ Pituitary Problems
▫ Blood Disorder	▫ GERD (Gastroesophageal/ Acid Reflux)	▫ Rheumatic Fever
▫ Blood Transfusions	▫ Heart Murmur	▫ Rheumatic Heart Disease
▫ Brain Injury	▫ Hemophilia	▫ Scarlet Fever
▫ Bruises Easily	▫ Hepatitis	▫ Scoliosis
▫ Cerebral Palsy	▫ High Blood Pressure	▫ Seizures
▫ Chronic Adenoid/Tonsil Infections	▫ Human Immunodeficiency Virus (HIV)/AIDS	▫ Sexually Transmitted Disease (STD)
▫ Congenital Heart Defect/Disease	▫ Hypoglycemia	▫ Sickle Cell Disease/Trait
▫ Cystic Fibrosis	▫ Irregular Heart Beat	▫ Sinusitis
▫ Cytomegalovirus (CMV)	▫ Jaundice	▫ Sleep Apnea
▫ Developmental Delay	▫ Liver Problems	▫ Thyroid Problems
▫ Diabetes (Type 1 / Type 2)		▫ Tuberculosis (TB)

8. If your child has any other conditions not previously listed please explain:

_____

9. Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions ..... ▫ YES ▫ NO

10. Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant ..... ▫ YES ▫ NO

If yes, please describe:_____

11. Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder... ▫ YES ▫ NO

12. Frequent colds or coughs, or pneumonia ..... ▫ YES ▫ NO

13. Frequent exposure to tobacco smoke ..... ▫ YES ▫ NO

14. Hydrocephaly/shunt placement (ventriculoperitoneal, ventriculoatrial, ventriculovenous). ▫ YES ▫ NO

15. Behavioral, emotional, communication, or psychiatric problems/treatment ..... ▫ YES ▫ NO

16. Abuse (physical, psychological, emotional, or sexual) or neglect ..... ▫ YES ▫ NO

Signature:_____ Relationship:_____ Date:_____