

**FACTS CONCERNING THE CHILD'S MEDICAL HISTORY
TO WHICH A PHYSICIAN SHOULD BE ALERTED**

Please indicate if student has had or is currently under treatment for any of the following conditions:

Give year or age when problem occurred.

_____ ASTHMA
_____ DIABETES
_____ EAR/HEARING PROBLEMS: (type) _____
_____ EMOTIONAL PROBLEMS: (type) _____
_____ SEIZURES
_____ HEART PROBLEMS: (type) _____
_____ HEPATITIS: (type) _____
_____ OTHER: _____

_____ MENINGITIS
_____ MIGRAINE HEADACHES
_____ MUSCULAR WEAKNESS OR PARALYSIS
_____ BLEEDING DISORDERS: (type) _____
_____ HIGH BLOOD PRESSURE
_____ INFECTIOUS DISEASE: (type) _____
_____ TETANUS SHOT: (date) _____

_____ ALLERGIES?

_____ REACTIONS TO MEDICINE OR INJECTIONS? _____

_____ HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS? _____

_____ LONG TERM MEDICATIONS? _____

_____ HAVE YOU EVER BEEN INFORMED OF THE NEED TO BE ON ANTIBIOTIC THERAPY PRIOR TO DENTAL TREATMENT? YES _____ NO _____
IF YES, IDENTIFY REQUIRED THERAPY _____

_____ PLEASE ADD ANY PROBLEMS NOT LISTED _____

Notes: