



**DENTAL HEALTH:** Please circle one: Excellent Good Fair Poor  
 Reason for Today's Visit: \_\_\_\_\_ Date of Last Dental Care: \_\_\_\_\_  
 How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_  
 What are your Dental Concerns for you Child? \_\_\_\_\_

**MEDICAL HEALTH:** Please circle one: Excellent Good Fair Poor  
 Physician's Name \_\_\_\_\_  
 Date of last complete physical: \_\_\_\_\_ Are you under a doctor's care now? \_\_\_\_\_ If yes, for what reason? \_\_\_\_\_ Do you smoke? Yes No  
 How many packs per day? \_\_\_\_\_ Have you ever received a blood transfusion? Yes No  
 When? \_\_\_\_\_ Are you subject to prolonged bleeding? Yes No  
 Soda consumption per day: \_\_\_\_\_ Candy consumption per day: \_\_\_\_\_

**Girls Only**  
 May Be Pregnant? Yes No  
 How many Months? \_\_\_\_\_  
 Are you taking Hormones or Contraceptives? \_\_\_\_\_

- Please CHECK if your child has had or have had any of the following:**
- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Heart Trouble           | <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Allergies                | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Prostate       |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Glaucoma       |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Hepatitis C    |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Frequent Cough           |   |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Lung Disease             |   |
| <input type="checkbox"/> Heart Pacemaker         | <input type="checkbox"/> Artificial Joint/Hips | <input type="checkbox"/> Liver Disease            |   |
| <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Kidney Trouble        | <input type="checkbox"/> Hepatitis A (infectious) |   |
| <input type="checkbox"/> Mitral Valve Prolapses  | <input type="checkbox"/> Ulcers                | <input type="checkbox"/> Hepatitis B (serum)      |   |
| <input type="checkbox"/> Epilepsy or Seizures    | <input type="checkbox"/> Alzheimer's Disease   | <input type="checkbox"/> Hypoglycemia             |   |
| <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Herpes/Cold Sores        |   |
| <input type="checkbox"/> Recent Weight Loss      | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Chemotherapy/Radiation   |   |
| <input type="checkbox"/> Thyroid Disease         | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> X-Ray/Cobalt Treatment   |   |

**Allergies**  
 Circle all allergies your child has:  
 Aspirin Sulfa Penicillin  
 Codeine Local Anesthetic  
 Latex Other: \_\_\_\_\_

**Medications**  
 List Medications Your Child is Taking:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 List Any Vitamins Your Child is Taking:  
 \_\_\_\_\_  
 \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Shur or any of her staff responsible for any errors of omissions that I may have made in the completion of this form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Update: Office use only**  
 Date: \_\_\_\_\_ Changes in H.H. \_\_\_\_\_  
 Date: \_\_\_\_\_ Changes in H.H. \_\_\_\_\_  
 Date: \_\_\_\_\_ Changes in H.H. \_\_\_\_\_

