

DENTAL INFORMATION

Patient First Name: _____ Last Name: _____ Birth Date: _____

- | | | | |
|---|---|---|--|
| | Y | N | |
| Is/Was your child bottle fed? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, until what age? _____ |
| Is/Was your child breast fed? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, until what age? _____ |
| Does your child like to snack during the day? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, what kind/how often? _____ |
| Does your child drink juices/sweetened drinks? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, what kind/how often? _____ |
| Has your child ever had injuries to his teeth, mouth, head or jaws? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, describe: _____ |
| Does your child brush daily? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Does an adult assist with the brushing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Does your child floss daily? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Does an adult assist with the flossing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Did the mother/caregiver have cavities in the last year? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, describe: _____ |
| Does your child have any of the following mouth habits? | | | |
| <input type="checkbox"/> Finger sucking | <input type="checkbox"/> Pacifier | <input type="checkbox"/> Lip sucking | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Tongue thrusting | <input type="checkbox"/> Mouth breather | |
| Does your child receive fluoride in any of the following forms? | | | |
| <input type="checkbox"/> Vitamins | <input type="checkbox"/> Water supply | <input type="checkbox"/> Tablets/drops | Dosage: mg/day <input type="checkbox"/> Toothpaste <input type="checkbox"/> Rinse/gel |

MEDICAL INFORMATION

Child's Pediatrician: _____ Address: _____ Phone: _____

Date of last physical? _____

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| Is your child in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your child's immunizations up to date? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child being treated for any condition presently? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, explain: _____ | | |
| Is your child taking any medications or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, explain: _____ | | |
| Has your child ever been hospitalized or had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, explain: _____ | | |
| Does your child have any allergies or reactions to any medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, explain: _____ | | |

Does your child have any allergies to the following: pollen food / food dyes dust latex other _____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table border="0"> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>AIDS</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Allergies to Medication</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Anemia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma/Lung Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Autism</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Behavior/Language Problems</td> </tr> </table> | Y | N | | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to Medication | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung Problems | <input type="checkbox"/> | <input type="checkbox"/> | Autism | <input type="checkbox"/> | <input type="checkbox"/> | Behavior/Language Problems | <table border="0"> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic Headaches</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic Ear Infections</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cleft Lip / Palate</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Convulsions / Seizures</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Endocrine System</td> </tr> </table> | Y | N | | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip / Palate | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine System | <table border="0"> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hemophilia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hepatitis or Liver Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hyperactivity</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Kidney Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Leukemia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental/Emotional</td> </tr> </table> | Y | N | | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Mental/Emotional | | | | | | | | | | | | | | | | | | | | | |
| Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to Medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Lung Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavior/Language Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Ear Infections | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip / Palate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions / Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine System | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental/Emotional | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Disturbances</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bladder Conditions</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blood Transfusions</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Birth Defects</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or Joint Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Brain Injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bruising Easily/ Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer or Malignancies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cerebral Palsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Child Abuse</td></tr> <tr><td><input 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<tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Eye Problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Excessive Bleeding Problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Excessive Gagging</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting or Dizziness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent Infections</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Growth & Development Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hearing/Speech Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Problems</td></tr> </table> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problem | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Gagging | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Infections | <input type="checkbox"/> | <input type="checkbox"/> | Growth & Development Problems | <input type="checkbox"/> | <input type="checkbox"/> | Hearing/Speech Problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems | <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nutritional Deficiency</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Oral Ulcers</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Orthopedic Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Premature Birth</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rheumatic Fever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle Cell Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Significant Injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Syndrome _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other _____</td></tr> </table> | <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency | <input type="checkbox"/> | <input type="checkbox"/> | Oral Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems | <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Significant Injury | <input type="checkbox"/> | <input type="checkbox"/> | Syndrome _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone or Joint Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruising Easily/ Abnormal Bleeding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or Malignancies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Child Abuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Adenoid/Tonsil Infection | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Problem | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Gagging | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Infections | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Growth & Development Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing/Speech Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral Ulcers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant Injury | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Syndrome _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered: _____

DDS Initials: _____