Medical History Form

Do you have any of the following Conditions?

Does your child have any of the following conditions? Please check yes or no.

Muscular dystrophy *
○ Yes ○ No

Immunizations are up to date *
○ Yes ○ No

Acid Reflux *
○ Yes ○ No

Acute Cerebellar Ataxia *
○ Yes ○ No

Acute lymphoblastic leukemia *
○ Yes ○ No

ADD/ADHD *
○ Yes ○ No

Anemia *
○ Yes ○ No

Aortic stenosis *
○ Yes ○ No

Arthritis *
○ Yes ○ No

Asthma *
○ Yes ○ No

Atopic Dermatitis *
○ Yes ○ No

Atrial Septal Defect (ASD) *
○ Yes ○ No

Autistic *
○ Yes ○ No

Behavioral Problems *
○ Yes ○ No

Bilateral Ostitis Media with Effusion *
○ Yes ○ No

Bleeding Disorder *
○ Yes ○ No

Born with dialated aorta *
○ Yes ○ No

Bottle/Sippy Cup *
○ Yes ○ No

Kidney/Renal Fusion *
○ Yes ○ No

Laryngomalacia *
○ Yes ○ No

Learning Disability *
○ Yes ○ No

Liver Disease *
○ Yes ○ No

Malignant hyperthermia *
○ Yes ○ No

Mastocytoma *
○ Yes ○ No

Mouth Breathing *
○ Yes ○ No

MTHFR (no nitrous) *
○ Yes ○ No

Neonatal Sepsis *
○ Yes ○ No

Nervous Disorder *
○ Yes ○ No

Non Verbal *
○ Yes ○ No

Nursing *
○ Yes ○ No

Obstructive Sleep Apnea *
○ Yes ○ No

Oppositional defiant disorder *
○ Yes ○ No

Oral Phase Dysphagia *
○ Yes ○ No

Pacifer *
○ Yes ○ No

Pain in Jaw (TMD) *
○ Yes ○ No

PANDAS *
○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

Bruxism (clenching/grinding) *

○ Yes ○ No

Cancer/Tumor *

○ Yes ○ No

Cerebral Palsy *

○ Yes ○ No

Congenital diaphragmatic hernia *

○ Yes ○ No

Craniosynostosis *

○ Yes ○ No

Developmental Delay *

○ Yes ○ No

Diabetes *

○ Yes ○ No

Dysphagia *

○ Yes ○ No

DiGeorge syndrome (22q11 syndrome) *

○ Yes ○ No

Dizziness *

○ Yes ○ No

Down's syndrome *

○ Yes ○ No

Duchenne muscular dystrophy *

○ Yes ○ No

Ear tubes *

○ Yes ○ No

Eczema *

○ Yes ○ No

Enterovirus Meningitis *

○ Yes ○ No

Eosinophilic Esophagitis *

○ Yes ○ No

Epilepsy *

○ Yes ○ No

Fainting *

○ Yes ○ No

G6PD deficiency *

○ Yes ○ No

Gastroschisis *

○ Yes ○ No

Peanut and artificial sweetner allergy *

○ Yes ○ No

Peripheral Pulomonary Stenosis *

○ Yes ○ No

Pertussis *

○ Yes ○ No

Pneumonia *

○ Yes ○ No

Poland syndrome *

○ Yes ○ No

Pre-Mature Birth, 35 weeks *

○ Yes ○ No

Ptosis *

○ Yes ○ No

PTSD *

○ Yes ○ No

Pyloric stenosis *

○ Yes ○ No

Pyruvate deficiency *

○ Yes ○ No

Relapsed kidney at birth *

○ Yes ○ No

Renal agenesis *

○ Yes ○ No

Respiratory Disease *

○ Yes ○ No

Respiratory issues - (or the process of being diagnosed) *

○ Yes ○ No

RSV *

○ Yes ○ No

Sacral Dimple *

○ Yes ○ No

Saethre Chotzen Syndrome *

○ Yes ○ No

Seasonal allergies *

○ Yes ○ No

Seizures *

○ Yes ○ No

Sickle Cell Anemia *

○ Yes ○ No

Generalized anxiety disorder *

◯ Yes ◯ No

Gilbert Syndrome *

◯ Yes ◯ No

Hearing Impairments *

◯ Yes ◯ No

Heart Murmur *

◯ Yes ◯ No

Heart Problems *

◯ Yes ◯ No

Hepatitis *

◯ Yes ◯ No

High Blood Pressure *

◯ Yes ◯ No

HIV/AIDS *

◯ Yes ◯ No

Hospital Stays *

◯ Yes ◯ No

Hydrocephalus *

◯ Yes ◯ No

Hypoglycemia *

◯ Yes ◯ No

Hypothyroidism *

◯ Yes ◯ No

Infectious Gastroenteritis/Colitis *

◯ Yes ◯ No

Inspiratory Stridor *

◯ Yes ◯ No

Kidney Disease *

◯ Yes ◯ No

Kidney Reflux *

◯ Yes ◯ No

Sickle cell trait *

◯ Yes ◯ No

Sleep apnea *

◯ Yes ◯ No

Speech Delay *

◯ Yes ◯ No

Subclavian Arterial Stenosis *

◯ Yes ◯ No

Teeth Clenching/Grinding *

◯ Yes ◯ No

Tongue Thrusting *

◯ Yes ◯ No

Tongue Tie *

◯ Yes ◯ No

Torticollis *

◯ Yes ◯ No

Traumatic Brain Injury *

◯ Yes ◯ No

Tuberous sclerosis *

◯ Yes ◯ No

Diabetes *

◯ Yes ◯ No

Vision Problems *

◯ Yes ◯ No

Rickets Disease *

◯ Yes ◯ No

Add unlisted conditions here (one item per entry)

Enter the item not listed here

Do you have any of the following Allergies?

Does your child have any of the following Allergies? Please check yes or no.

Aspirin *

Yes No

Metals *

Yes No

Codeine *

Yes No

Milk *

Yes No

Dyes *

Yes No

Peanuts *

Yes No

Egg *

Yes No

Treenuts *

Yes No

Latex *

Yes No

Add unlisted allergies here (one item per entry)

Enter the item not listed here

I have disclosed all allergies. *

Are you taking any of the following Medications?

Is your child currently taking any medications? Please check yes or no.

Acyclovir *

Yes No

Fluoride Supplements *

Yes No

Adalimumab *

Yes No

Fluoxetine *

Yes No

Adderall *

Yes No

Folic acid *

Yes No

Advil *

Yes No

Humaira *

Yes No

Alazapram *

Yes No

Iron supplement *

Yes No

Albuterol *

Yes No

Lamictal *

Yes No

Allegra *

Yes No

Levemir *

Yes No

Amoxicillin *

Yes No

Lexapro *

Yes No

Ativan *

Yes No

Lorazepam *

Yes No

Atomoxetine *

Yes No

Miralax *

Yes No

Benedryl *

Yes No

Multivitamin *

Yes No

Bilsovi *

○ Yes ○ No

Budesonide *

○ Yes ○ No

Clonidine *

○ Yes ○ No

Concerta *

○ Yes ○ No

Dulera *

○ Yes ○ No

Eczema cream *

○ Yes ○ No

Effexor *

○ Yes ○ No

Epi-Pen *

○ Yes ○ No

Flovent *

○ Yes ○ No

Novalog *

○ Yes ○ No

Omnitrop *

○ Yes ○ No

Polyethylene Glycol *

○ Yes ○ No

Prednisolone *

○ Yes ○ No

Prozac *

○ Yes ○ No

QVAR *

○ Yes ○ No

Respidome *

○ Yes ○ No

Ritalin *

○ Yes ○ No

Sertaline *

○ Yes ○ No

Singulair *

○ Yes ○ No

Strattera *

○ Yes ○ No

Symbicort *

○ Yes ○ No

Synthroid *

○ Yes ○ No

Tylenol *

○ Yes ○ No

Vitamin D *

○ Yes ○ No

Xopenex *

○ Yes ○ No

Add unlisted medications here (one item per entry)

Enter the item not listed here

☐ I have disclosed all medications I currently take. *

Additional Questions

Please complete the following.

Does your child experience any pain in their teeth? *

◯ Yes ◯ No

Does your child experience any tooth sensitivity? *

◯ Yes ◯ No

Does your child grind their teeth? *

◯ Yes ◯ No

Are there any other health issues or concerns that were not listed? *

◯ Yes ◯ No

Patient's First Name *

Patient's Last Name *