

**MINOR CHILDS HEALTH HISTORY UPDATE**

Patient Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

**Do any of the following pertain to your child's health?    Yes (please circle)    No**

- |                                  |                         |                          |
|----------------------------------|-------------------------|--------------------------|
| Heart Failure                    | Ulcers                  | Chemotherapy             |
| Heart Disease / Attack           | Cosmetic Surgery        | Cancer / Leukemia        |
| Angina Pectoris                  | HIV / AIDS              | Venereal Disease         |
| High Blood Pressure              | Hepatitis A             | Bruise Easily            |
| Functional Heart Murmur          | Hepatitis B             | Emphysema                |
| Non functional Heart murmur      | Liver Disease           | Tuberculosis (TB)        |
| Rheumatic Fever                  | Yellow Jaundice         | Asthma                   |
| Congenital Heart Lesions         | Blood Transfusion       | Hay Fever                |
| Scarlet Fever                    | Drug Addiction          | Sinus Trouble            |
| Artificial Heart Valve           | Hemophilia              | Allergies / Hives        |
| Heart Pacemaker                  | Cold Sores              | Diabetes                 |
| Heart Surgery                    | Epilepsy / Seizures     | Thyroid Disease          |
| Artificial Joints<br>(Hip, knee) | Fainting / Dizzy Spells | X-ray / Cobolt Treatment |
| Anemia                           | Nervousness             | Rheumatism               |
| Stroke                           | Psychiatric Treatment   | Cortisone Injections     |
| Kidney Trouble                   | Sickle Cell Disease     | Pain in Jaw Joints       |
|                                  | Glaucoma                | High Cholesterol         |

**Any other medical condition(s) not listed?    Yes (please list)    No**

**Any allergies or adverse reactions to the following?    Yes (please circle)    No**

- |               |                  |                    |
|---------------|------------------|--------------------|
| Aspirin       | Local Anesthetic | Penicillin         |
| Darvon        | Codeine          | Latex              |
| Nitrous Oxide | Erythromycin     | Mint               |
| Percodan      | Valium           | <b>Other</b> _____ |

**Is the patient taking any medications?    Yes (please list)    No**

**Permission for Dental Examination and Treatment of a Minor**

I, as the parent or guardian of this minor child, do hereby authorize and consent to any x-rays, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Martin and his or her associates and staff members he may deem necessary. This authorization will remain in effect until cancelled in writing by me.

**Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_