Beautiful SMILES Family Dental Center

Medical History Update
Children Under 18yrs

564 Old York Road
Etters, PA 17319
Phone: (717) 938-1811
Fax: (717) 938-1815
contact@welovebeautifulsmiles.com
www.welovebeautifulsmiles.com

First Name:____________________**Last Name:**____________________**MI:**___**Preferred:**_______________

Date of Birth:______/_____/__________ **Sex:** ☐ **Male** ☐ **Female**

How would you rate your overall health? ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician for an ongoing condition? ☐ Yes ☐ No

Any serious illness, operations, or been hospitalized within the past 5 years? ☐ Yes ☐ No

If yes, for what reason? ____________________________

Have you had any cosmetic procedures or elective surgeries completed? ☐ Yes ☐ No

If yes, please describe: __________________________________Treating Physician: ____________________

Address:______________________City:______________State:_____Zip:_____Phone #:_________________

Have you had medical x-rays in the last 5 years? (CT Scan/MRI, etc.) ☐ Yes ☐ No

If yes, please explain: ____

MEDICATIONS & SUPPLEMENTS

Name	Dose	Frequency	Reason

Do you use tobacco? ☐ Yes ☐ No **Do you vape?** ☐ Yes ☐ No **Do you use marijuana?** ☐ Yes ☐ No

Have you been prescribed a medical marijuana card? ☐ Yes ☐ No

Do you, or have you used recreational or street drugs? ☐ Yes ☐ No If yes, how often? _______________

If yes, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not Interested

Do you drink alcoholic beverages? ☐ Yes ☐ No **How Many per Week?** ☐ < 1 ☐ 2-4 ☐ >5

____________________________________ ____________________

Reviewing Doctor's Signature **Date**

Revised July 2024

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MEDICAL CONDITIONS

Check any of the following conditions you currently have ***or have had*** in the past:

CARDIOVASCULAR CONDITIONS — **If none of these apply check: □ NONE**

□ Angina
□ Congenital Defect
□ Irregular Heartbeat
□ Arteriosclerosis
□ Damaged Heart Valves
□ Mitral Valve Prolapsed
□ Artificial Valves
□ Heart Attack
□ Pacemaker
□ Chest Pain Upon Exertion
□ Heart Murmur
□ Rheumatic Heart Disease
□ Congenital Heart Failure
□ Heart Surgery
□ Scarlet Fever
□ Coronary Artery Disease
□ High Blood Pressure
□ Stroke
□ Other (please specify): ____________________

RESPIRATORY CONDITIONS — **If none of these apply check: □ NONE**

□ Asthma
□ Hay Fever
□ Sinus Problems
□ Bronchitis
□ Persistent Cough/Produces Blood
□ Tuberculosis (TB)
□ Emphysema
□ Shortness of Breath
□ Other (please specify): ____________________

BLOOD DISORDERS — **If none of these apply check: □ NONE**

□ Abnormal Bleeding
□ Bruise Easily
□ Leukemia
□ Anemia
□ Excessive Bleeding
□ Sickle Cell Disease
□ Blood Transfusion
□ Hemophilia
□ Other (please specify:____________________

PSYCHOLOGICAL CONDITIONS — **If none of these apply check: □ NONE**

□ Anxiety □ Depression □ Nervousness □ Psychiatric Treatment
□ Other (please specify): ____________________

LIVER CONDITIONS — **If none of these apply check: □ NONE**

□ Cirrhosis/Liver Disease □ Hepatitis □ Jaundice
□ Other (please specify): ____________________

OTHER HEALTH CONDITIONS — **If none of these apply check: □ NONE**

□ Allergies or Hives
□ Cortisone Medication
□ Herpes
□ Rheumatism
□ Arthritis
□ Diabetes
□ HIV Antibody/AIDS
□ STD
□ Artificial joint
□ Drug Addiction
□ Kidney Disease/Dialysis
□ Stomach Problems
□ Cancer
□ Epilepsy or Seizures
□ Measles
□ Thyroid disease
□ Chemotherapy
□ Fainting or Dizzy Spells
□ Mumps
□ Tumor
□ Cold Sores/Fever Blisters
□ Glaucoma
□ Radiation Treatment
□ Ulcers

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ALLERGIES

IF NO ALLERGIES CHECK NONE: □ **NONE**

Type **Reaction (i.e. itching, rash, swelling of hands, eyes, or feet)**

□ Drugs/Other Medications ______________________________

□ Foods ______________________________

□ Metals ______________________________

□ Other ______________________________

Are you on a special diet? □ Yes □ No

If yes, please describe here: ______________________________

Have you lost or gained more than 10 pounds in the last year? □ Yes □ No

Do you have any disease, condition, or problem that was not previously listed? □ Yes □ No

If yes, please describe here: ______________________________

*****WOMEN ONLY*****

Are you pregnant? □ Yes □ No **Are you looking to become pregnant?** □ Yes □ No

Are you nursing? □ Yes □ No **Are you using a contraceptive?** □ Yes □ No

If yes, ***initial the following statement***: I understand that taking antibiotics may render contraceptives ineffective. ________

MEDICAL HISTORY ACKNOWLEDGEMENT

To the best of my knowledge all of the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to **all** appointments.

This agreement and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures appearing on this agreement, or such other documents are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

______________________ ______________________ ______________________

Parent/Guardian Name (Print) **Type Name for Signature** **Date**

______________________ ______________________

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