James M. Cooper D.D.S.

MEDICAL HISTORY- Minor

Date_____

Name_____ Preferred Name _____

Address_____ City_____ Zip _____

Lives With _____ Date of Birth _____

Home Phone _____ Cell_____ Other _____

E-Mail to confirm _____

Where/whom Should We Confirm_____

May We Text You **YES NO** May We E-mail You **YES NO** May We Leave a Message **YES NO**

Primary Care Physician_____ Phone _____

Pharmacy Name and Number_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? THIS INFORMATION IS REQUIRED SO WE MAY WE MAY PROVIDE THE SAFEST AND APPROPRIATE TREATMENT FOR OUR PATIENTS.

___ High or low blood pressure
___ Medication for BP YES NO
___ Heart murmur, mitral valve prolapse
___ Artificial heart valve or damaged valves
___ Heart ailment or angina
___ Blood Thinners/Medication _____
___ Bypass surgery
___ Coronary stents
___ Cardiac pacemaker or defibrillator
___ Abnormal heart rhythm
___ Artificial joints Date _____
___ Stroke
___ Blood disorder or bleeding problems
___ Hepatitis A B C
___ Liver disease
___ Kidney disease
___ Tuberculosis
___ Emphysema
___ Chronic bronchitis
___ Asthma
___ COPD
___ Tobacco use
___ Diabetes Type 1 2
___ Arthritis
___ Hearing impairment

___ Congenital Birth Defects
___ Behavioral/ Learning Disorder
___ Handicaps/Disabilities
___ Hay fever or sinus problems
___ Dry mouth
___ Cancer
___ Radiation / Chemo
___ Thyroid disorder
___ Epilepsy, seizures, or fainting spells
___ Herpes or cold sores
___ AIDS / H.I.V Positive
___ Gastrointestinal problems
___ Eye or ear problems
___ Migraine or frequent headaches
___ Dizziness
___ Frequent yeast or candida infection
___ Allergies or Reaction to Medication
Epinephrine_____
Sulfa_____
Penicillin_____
Latex_____
Anesthetics_____
Other _____
_____

Name:_____ **Date of Birth**: _____

1. Is this your child's first visit to the dentist?_____ If not, how long since last visit._____
2. Have there been any injuries to the teeth, face or mouth? _____

_____

3. Does your child have any of the following?

   _____Lip Sucking or Biting ___ Nursing/ Bottle Habits___ Nail Biting ____ Thumb/ Finger Sucking

4. Has your child been hospitalized or had surgery within the past 5 years? Yes No

   Please explain_____

5 Is your child under the care of a physician for any current health issues? Yes No

   Please explain:_____

   _____

6. Has your child had excessive bleeding or trouble following dental treatment? Yes No
7. Does your child require Antibiotics before dental treatment? Yes No

   Reason:_____

5. Has your child recently traveled out of the country? If so, where_____
6. List ALL drugs or medications that your child is taking…including prescription / non-prescription drugs, Aspirin, Birth control pills, herbal treatments, and vitamins.

Prescribed Current Medications	**Over the Counter Medications**
_____	_____
_____	_____
_____	_____

Do you have any dental concerns or anything you would like to address with the dentist or hygienist:

_____

_____

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE **DATE**

Reviewed by:_____ Date _____ Reviewed by:_____ Date _____
Reviewed by:_____ Date _____ Reviewed by:_____ Date _____
Reviewed by:_____ Date _____ Reviewed by:_____ Date _____