

Smiles for the Future Pediatric Dentistry & Orthodontics **HEALTH & SOCIAL HISTORY**

1. Does the patient have any health problems (past or present)? If yes, explain 2. Is the patient currently seeing a physician for any problem? If yes, explain 3. Does the patient face any medications? If yes, explain 4. Does the patient face and allergy to any food, medicine or materials (e.g. antibiotics, latex)? a Yes a No If yes, explain 5. Hose the patient have an allergy to any food, medicine or materials (e.g. antibiotics, latex)? a Yes a No If yes, explain 6. Has the patient ever had a heart murmur, heart defect or rheumatic fever? If yes, explain 7. Has the patient ever been injured, hospitalized or received surgery? If yes, explain 7. Has the patient ever had a blood transfusion? 8. Has the patient ever had any of the following: Breathing problems or asthma? Almay, tonsil or adenaid problems? Blood problems such as sickle cell anemia? Easy bleeding or bruising? Beautiful to the color of the patient ever had a blood transfusion? Seizures, lizzines, fainting spells or epilepsy? Frequent headaches? Brequent cough or tuberculosis (T.B.)? Hepatitis or liver problems? Stomach, bowel problems or gastric reflux? Diabetes, excessive thirst or uninotion? Other endocrine or hormone problems? AlDS or HIV Infection? General anesthesia? Brith defect or disability? Pess a No If yes, explain Diabetes, excessive thirst or uninotion? Does anyone in the immediate family have a history of allergies, diabetes, etc.? Tyes a No If yes, explain Diabetes had any disease, condition or problem not listed above? Frequent had any disease, condition or problems for a filter patient had any disease, condition or problems or distribution. Brith defect or disability? Does anyone in the immediate family have a history of allergies, diabetes, etc.? Tyes a No If yes, explain Dia the patient had any disease, condition or problem not listed above? Frequent had any disease, condition or problem not listed above? Pess a No If yes, explain Does the patient had any disease, condition or problem not listed ab		tient Name:					
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