MCHC – CHILD AND ADOLESCENT DENTISTRY MEDICAL EVALUATION Chart

	YES	NO	NAME (LAST (FIRST) (MIDDLE)	AGE	DATE OF BIRTH	SEX	DATE	INTERVIEWER

1	Child's Overall Health: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR			If yes, please explain
2			Has the child gone to the doctor in the last six months?	
3			Is the child currently on any medications? Or been on medications in the last 6 months?	
4			Is the child allergic to any medications (Example: Penicillin)?	
5			Does the child have asthma, allergies or hay fever?	
6			Does the child have a colds or sore throat more than once a year?	
7			Has the child ever had any serious injuries? Has the child ever been in a serious accident? Has the child ever been in the hospital? Has the child ever received a blood transfusion?	
8			Is the child emotionally, mentally or physically delayed or impaired in any way?	
9			Has the child ever seen a psychiatrist or psychologist?	
10			Has the child ever had convulsions or seizures? Does the child have any nervous system disease?	
11			Is the child pregnant?	
12			Has the child ever had yellow jaundice or liver disease? Has the child ever had hepatitis or a positive test for hepatitis?	
13			Has the child ever been exposed to venereal disease (gonorrhea, herpes, syphilis)?	
14			Does the child have heart disease or a heart murmur? Has the child ever had rheumatic fever?	
15			Has the child ever had radiation therapy?	
16			Does the child have any hormone disease or problems?	
17			Does the child have any stomach or intestinal problems? Has the child ever had a hernia?	
18			Does the child have any kidney or bladder problems?	
19			Does the child have any lung disease or bronchial disease? Has the child ever had tuberculosis or trouble breathing?	
20			Does the child have any blood disease (hemophilia, sickle cell anemia)? Does the child have the sickle cell trait?	
21			Does the child bleed for a long period of time when they cut themselves or have a tooth take out?	
22			Has the child ever taken any illegal drugs? Does the child have a tattoo?	
23			Has the child ever had night sweats, a fever or weight loss for no reason? Have you noticed any lumps in the child's neck, armpit, or groin area?	
24			Are there any discolored areas of the child's skin or mouth? Does the child have a persistent cough or persistent diarrhea?	
25			Has the child ever had a positive test for AIDS, ARC, or AIDS antibodies?	
26			Has the child ever been exposed to anyone who has been diagnosed with AIDS or AIDS antibodies?	
27			Has the child ever been exposed to anyone who has been diagnosed with hepatitis or a history of IV drug use, or treatment with a kidney machine?	
28			Is there a family history of tuberculosis or diabetes? Is there a family history of any other illnesses or diseases?	
29			Does the child have any other medical problems that have not been mentioned above?	

Name of Physician:	**Phone:**	**Pharmacy:**	**Phone:**

DENTIST SUMMARY		History Update	Interviewer
	OK for Routine Dental Treatment: -Dentist signature and date-		

DENTAL HISTORY What is the purpose of your visit?

Do you have any questions about your child's teeth?

Date of last dental visit: Where: Reaction to last visit:

Services provided at last visit

APPROVAL OF MEDICAL HISTORY

I, _____ DATE _____,

certify the above is accurate and my relationship to the child is: ☐ mother ☐ father ☐ foster parent/relative care giver/legal guardian