SHAHNAZ B. AHMED D.D.S.
956 Kehrs Mill Road, Ballwin, MO 63011

MEDICAL HISTORY

Child's name: _____

Sex: _____ Birthdate: _____ Date of last medical examination: _____

Child's physician/pediatrician: _____

Physician/Pediatrician phone No.: _____

Physician's address: _____

GROWTH AND DEVELOPMENT:

Any learning, behavioral, excessive nervousness, or communication problems?	Y	N
Has child had psychological counseling or is counseling being considered for the near future?	Y	N
Were there any complications during pregnancy or was child premature at birth?	Y	N
Any problems with physical growth?	Y	N

CENTRAL NERVOUS SYSTEM

Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	Y	N
Any history of injury to the head?	Y	N
Any sensory disorders? (Seeing, hearing)	Y	N

CARDIOVASCULAR SYSTEM

Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever?	Y	N
Has any heart surgery been done or recommended?	Y	N
Any history of chest pains or high blood pressure?	Y	N

HEMATOPOIETIC AND LYMPHATIC SYSTEMS

Has your child ever had a blood transfusion or blood products transfusion?	Y	N
Any history of anemia or sickle cell disease?	Y	N
Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts?	Y	N

Is there any history of tender or swollen lymph nodes or glands?	Y	N

RESPIRATORY SYSTEM

Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing?	Y	N

GASTROINTESTINAL SYSTEM

Any history of stomach, intestinal or liver problems?	Y	N
Any history of hepatitis or jaundice?	Y	N
Any history of eating disorders, such as anorexia nervosa or bulimia (binge/purge)?	Y	N
Any history of unintentional weight loss?	Y	N

GENITOURINARY SYSTEM

Any history of urinary track infections, bladder or kidney problems?	Y	N
Is the patient pregnant or possibly pregnant?	Y	N

ENDOCRINE SYSTEM

Any history of diabetes?	Y	N
Any history of thyroid disorders or other glandular disorders?	Y	N

SKIN

Any history of skin problems?	Y	N
Any history of cold sores (herpes) or canker sores (aphthae)?	Y	N

EXTREMITIES

Any limitations of use of arms or legs?	Y	N
Any arthritis, joint bleeding, joint replacements or other joint problems?	Y	N
Any problems with muscle weakness or muscular dystrophy?	Y	N

ALLERGIES

Is your child allergic to any mediations?	Y	N
Any hay fever, hives, or skin rashes caused by allergies?	Y	N
Any other allergies?	Y	N

If you answered yes to any of the above questions, please explain below:

_____

_____

MEDICATIONS OR TREATMENTS

Is your child currently taking any mediation (prescription or non-prescription medicine)?	Y	N

If yes, Medication (s)	Dosage	Times per day
_____	_____	_____
_____	_____	_____

Has your child ever received radiation therapy (x-ray treatments) or is it planned? Y N
Has your child ever received chemotherapy or is it planned? Y N

HOSPITALIZATIONS

Has your child been hospitalized? Y N
If yes, dates and reason

Date	Reason
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS

Is your child presently protected by immunization against DPT: diphtheria, whooping cough (pertussis), tetanus? Y N
OPV: Polio or Poliomyelitis? Y N
MMR: Measles (rubeola), mumps, and German measles (rubella)? Y N
Hib or HbPV (haemophilus b vaccine)? Y N
Please check any of the following that your child has now, has recently been exposed to, or has had in the past:

	Now	Exposed	Past
Chicken pox (varicella)	_____	_____	_____
Earache (otitis)	_____	_____	_____
Eye infection (conjunctivitis)	_____	_____	_____
German measles or 3-day measles (rubella)	_____	_____	_____
Glandular fever or mono (infectious mononucleosis)	_____	_____	_____
HIV/AIDS	_____	_____	_____
Lead poisoning	_____	_____	_____
Measles (rubeola)	_____	_____	_____
Mumps (parotitis)	_____	_____	_____
Scarlet Fever (scarlatina)	_____	_____	_____
Sore throat (tonsillitis or pharyngitis)	_____	_____	_____
Substance abuse, alcoholism, drug addiction	_____	_____	_____
Tuberculosis	_____	_____	_____
Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, or tonsillitis)	_____	_____	_____
Venereal disease (genital herpes, gonorrhea, syphilis or other)	_____	_____	_____

DENTAL HISTORY

Does your child have a toothache or other immediate dental problem? Y N
Has your child ever had a toothache? Y N
Has your child had any injury to the mouth, teeth or jaws (fall, blow, etc.)? Y N
Is this your child's first dental visit? Y N

If no: Date: _____ Dentist: _____

Reason _____

Has your child ever had an unfavorable dental experience? Y N
Is (was) your child nourished by nursing beyond one year of age? Y N
If yes, check: Breast ___ Nursing bottle ___, Both ___, and to what age? _____
Does your child fail to eat a well-balanced diet? Y N
If yes, what foods or food groups are not adequate? _____
Does (or has) your child have (or had) sucking habit beyond one year of age? Y N
If yes, check: thumb (s) _____ finger(s) _____ Pacifier _____ Other _____
Does (or has) your child have (or had) any other oral habits beyond one year of age? Y N
If yes, check: lip biting __ Mouth breathing __ Nail biting __ teeth grinding __ other ____
Does (or has) your child have (or had) difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in a certain position? Y N
Does (or has) your child have (or had) popping or clicking noises or pain during chewing or yawning? Y N
Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes or cheeks? Y N

DENTAL DISEASE PREVENTION

How often does your child brush? _____ times per _____
Does your child use dental floss? Y N
Does someone assist your child with brushing and cleaning the teeth? Y N
Does someone inspect for thoroughness after the procedure? Y N
Does your child use a fluoride toothpaste? Y N
Has your child ever had a fluoride treatment? Y N
Has your child ever taken a fluoride supplement or vitamins with fluoride? Y N
Drinking water source: City water supply or well water (Circle your choice)

Name of city _____

If private well or other than city , has a fluoride analysis been done? Y N

If yes, Date of analysis _____ Fluoride content _____

_____
Signature of parent or guardian Date

_____
Print parent or guardian's name