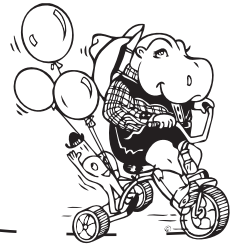
Alexandria pediatric Dentistry



**MEDICAL HISTORY UPDATE FORM**

child's name: _____
child's school: _____ grade: _____ child's pediatrician: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST US IN KEEPING YOUR CHILD'S MEDICAL HISTORY UP TO DATE
Has your child seen his/her physician since the last visit? Y/N If so, why? _____
Has your child's medical history changed since the last visit? Y/N If so, how? _____
Is your child taking any medications at the present time? Y/N

| Name of medication | Reason |
|---|---|
| | |
| | |

Does your child have any new allergies? Y/N Please list _____
Any injury to head or neck in the last 6 months? Y/N If so, what? (Ex:front teeth) _____
Any dental problems developed or developing?Y/N Please explain: _____
IN ORDER TO CONTINUE TO PROVIDE THE BEST POSSIBLE CARE OF YOUR CHILDREN, WE NEED AND APPRECIATE YOUR SUGGESTIONS:
Do you feel like you are well treated in our office? Y/N
If you marked no, please explain _____

date: _____ signed: _____ relationship to child: _____