



**alexandria
pediatric
dentistry**

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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:

Have you been satisfied with the care in the past? Y / N

If you marked no, please explain _____

date: _____ signed: _____ relationship to child: _____

