auroradentalcentre
89 Wellington St. East Aurora, ON L4G 1H7
phone: 905.727.9220

CHILD MEDICAL QUESTIONNAIRE

1.What is this patient's medical Doctor's name? ____________________________
2.Is this patient currently taking any medication? □ yes □ no □ not sure
If yes, please list ALL medications ____________________________
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3.What is this patient's medical Doctor's phone number ____________________________
4.Date of last complete physical examination? ____________________________
5.Is this patient currently under a physician's care? □ yes □ no □ not sure

Medications-Reactions or Allergies

6. Has this patient ever had an adverse reaction to Latex? □ yes □ no □ not sure
7.Has this patient ever had an adverse reaction to any Metal? □ yes □ no □ not sure
8.Has this patient ever had an adverse reaction to Aspirin? □ yes □ no □ not sure
9.Has this patient ever had an adverse reaction to any medications? □ yes □ no □ not sure
10.Has this patient ever had an adverse reaction to Codeine? □ yes □ no □ not sure
11.Has this patient ever had an adverse reaction to Penicillin? □ yes □ no □ not sure
12.Has this patient ever had an adverse reaction to Sulfa Drugs? □ yes □ no □ not sure
13.Has this patient ever had an adverse reaction to Local Anesthetic(freezing)? □ yes □ no □ not sure
14.Has this patient ever had an adverse reaction to Nitrous Oxide? □ yes □ no □ not sure
15.Has this patient ever had an adverse reaction to any other drugs? □ yes □ no □ not sure
16.Has this patient ever been treated for or told they have Arthritis? □ yes □ no □ not sure
17.Has this patient ever been treated for or told they have Asthma? □ yes □ no □ not sure
18.Has this patient ever been treated for or told they have a Blood Disorder such as Anemia or Leukemia? □ yes □ no □ not sure
19.Has this patient ever been treated for or told they have Cancer? □ yes □ no □ not sure
20.Has this patient ever been treated for or told they have Diabetes? □ yes □ no □ not sure
21.Has this patient ever been treated for or told they have Epilepsy? □ yes □ no □ not sure
22.Has this patient ever experienced heavy bleeding? □ yes □ no □ not sure
23.Has this patient ever been treated for or told they have a Heart Murmur? □ yes □ no □ not sure
24.Has this patient ever been treated for or told they have Hepatitis B? □ yes □ no □ not sure
25.Has this patient ever been treated for or told they have HIV(AIDS)? □ yes □ no □ not sure
26.Has this patient ever had any Joint Replacement? □ yes □ no □ not sure
27.Has this patient ever been treated for or told they have Liver Disease? □ yes □ no □ not sure
28.Has this patient ever been treated for or told they have a Mental Disability(by a doctor)? □ yes □ no □ not sure
29.Has this patient ever been treated for or told they have Renal Disease? □ yes □ no □ not sure
30.Has this patient ever been treated for or told that have Rheumatic Fever? □ yes □ no □ not sure
31.Has this patient ever been treated for or told they have Thyroid Disorder? □ yes □ no □ not sure
32.Has this patient ever been treated for or told they have Tuberculosis? □ yes □ no □ not sure
33. Is there anything else we should know? □ yes □ no □ not sure
____ ______________________________

I HEREBY CERTIFY THAT I HAVE FILLED OUT THIS FORM ON BEHALF OF THIS PATIENT AND HAVE NOT KNOWINGLY OMITTED ANY IMPORTANT INFORMATION REGARDING THEIR HEALTH WHICH MAY EFFECT THEIR SAFETY AND THE SAFETY OF THE DOCTOR AND STAFF

PATIENT NAME: ____

PARENT/GUARDIAN: NAME: ____

PARENT/GUARDIAN SIGNATURE: ____

DATE: ____

DOCTOR'S SIGNATURE: ____