Dentistry 4 Kidz
#1 Eureka Circle #103
Wichita Falls, TX 76308

	Circle
ADD	No Yes
ADHD	No Yes
Asthma	No Yes
Autism Spectrum	No Yes
Allergies	No Yes
Seasonal/Environmental	
Any Hospital Stays	No Yes
Any Operations	No Yes
Autoimmune Disorders	No Yes
Bleeding Disorders	No Yes
Birth Defects	No Yes
Brain Damage or Neurologic Problems	No Yes
Developmental Problems	No Yes
Diabetes	No Yes
Hearing Impairment	No Yes
Hypoglycemia- Low Blood Sugar	No Yes
Heart Disease or Heart Murmur	No Yes
Liver Problems	No Yes
Rheumatic Fever	No Yes
Seizures or Convulsions	No Yes
Sickle Cell Disease or Trait	No Yes
Tuberculosis (TB)	No Yes
Cancer/ Malignant Tumor	No Yes
Radiation?	No Yes
Chemotherapy?	No Yes

Has the patient had any or ever been exposed to the following:

Hepatitis	Had	Exposed to	Date_____
Herpes	Had	Exposed to	Date_____
HIV/AIDS	Had	Exposed to	Date_____
Scarlet Fever	Had	Exposed to	Date_____

Review of Systems

Has the patient had any of the following problems?

Dizziness/ Fainting Spells	No Yes
Eye Problems	No Yes
Headaches	No Yes
Ear Infections	No Yes
Nose Bleeds	No Yes
Sleep Apnea	No Yes
Sore Throat	No Yes
Runny Nose	No Yes
Breathing Problems	No Yes

	Circle
ADD	No Yes
ADHD	No Yes
Asma	No Yes
Autismo	No Yes
Alergias	No Yes
Temporada/ Ambienales	
Hospitalizacion	No Yes
Operaciones	No Yes
Trastornos autoinmunitarios	No Yes
Trastornos hemorragicos	No Yes
Defectos congenitos	No Yes
Dano cerebral	No Yes
Problemas de desarrollo	No Yes
Diabetes	No Yes
Problemas de audicion	No Yes
Hipoglucemia	No Yes
Enfermedad o soplo cardiac	No Yes
Problemas de higado	No Yes
Fiebre reumatica	No Yes
Convulsiones o epilepsia	No Yes
Anemia drepanocitica o rasgo	No Yes
Tuberculosis (TB)	No Yes
Cancer/Tumor malign	No Yes
Radiacion?	No Yes
Quimioterapia?	No Yes

Ha padecido el paciente o alguna vez ha estado expuesto a alguno de los siguientes?

Hepatitis	Had	Exposed to	Date_____
Herpes	Had	Exposed to	Date_____
HIV/AIDS	Had	Exposed to	Date_____
Escarlatina	Had	Exposed to	Date_____

Examen de los sistemas corporals

Ha presentado el paciente alguno de los siguientes problemas?

Mareos/Desmayos	No Yes
Problemas de la vista	No Yes
Dolores de cabeza	No Yes
Infecciones de oido (otitis)	No Yes
Hemorragia Nasal	No Yes
Apnea del sueno	No Yes
Dolor de garganta	No Yes
Nariz aguada	No Yes
Problemas respiratorios	No Yes

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Pneumonia	No	Yes
Teeth/ Sore Gums	No	Yes
Stomach Problems	No	Yes
Kidney/ Bladder Problems	No	Yes
Sore Joints	No	Yes
Muscle Weakness	No	Yes
Genetic Disorders	No	Yes
Endocrine/ Hormone Problems	No	Yes

Family History
Do any family members have any medical problems? If yes, please list which family member.

Bleeding Disorder	No	Yes _____
Asthma	No	Yes_____
Birth Defects	No	Yes_____
Diabetes	No	Yes_____
Hypoglycemia	No	Yes_____
Neuromuscular Problems	No	Yes_____
Sickle Cell Disease	No	Yes_____
Seizures or Convulsions	No	Yes_____
Trouble with Anesthesia	No	Yes_____
Malignant Hyperthermia	No	Yes_____

Additional Information:

_____
_____
_____
_____
_____
_____

Signatures
Assistant Name: _____
Assistant Signature:_____
Date:_____ Time: _____
Parent/Legal Guardian Signature:_____
Date:_____ Time: _____
I have reviewed the above information.
Dr. Signature: _____
Date:_____ Time: _____

	Circle	
Neumonia	No	Yes
Dolor de dientes o encias	No	Yes
Problemas estomacales	No	Yes
Problemas renales o de vejiga	No	Yes
Articulaciones adoloriadas	No	Yes
Debilidad muscular	No	Yes
Trastornos geneticos	No	Yes
Problemas endocrinos u hormonales	No	Yes

Antecedentes Famillares
Alguno de sus familiars tiene algun problema medico? Si la prespuesta es si, indique que familiar.

Trastornos hemorragicos	No	Yes_____
Asma	No	Yes_____
Defectos congenitos	No	Yes_____
Diabetes	No	Yes_____
Hipoglucemia	No	Yes_____
Problemas neuromusculares	No	Yes_____
Anemia drepanocitica	No	Yes_____
Convulsions o epolepsia	No	Yes_____
Problemas con la anesthesia	No	Yes_____
Hipertermia maligna	No	Yes_____

Informacion Adicional:

_____
_____
_____
_____
_____
_____

Firmas
Nombre del Assistente:_____
Firma del Assistente:_____
Fecha:_____ Hora: _____
Firma del padre o tutor lega:_____
Fecha:_____ Time:_____
He revisado la informacion que preceded.
Firma del medico:_____
Fecha: _____ Time:_____

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Source of Information
Primary Care Physician: _____
Referring Physician/Clinic: _____
Diagnosis: _____
Person Providing Information: _____
Relationship to patient: _____
Language Spoken: _____

How did you hear about us?
_____

Chief Complaint
Reason for today's visit: _____
_____

Past History
Are immunizations UP TO DATE? No Yes
Is the patient allergic to any medications No Yes
If yes, please list: _____
Please list reactions: _____
Is the patient allergic to LATEX? No Yes
Is the patient taking prescribed medications?
Medications Dose Times Per Day
_____
_____
_____
_____
What was the patient's birth weight?
____pounds ____ounces
Was the patient premature? No Yes
Did the patient have breathing problems? No Yes
Did the patient have jaundice? No Yes
Did the patients have blood transfusions? No Yes
Did the patient stay in the newborn ICU? No Yes
Did the patient have complications during birth?
If yes, please explain: _____
_____

Has the patient ever been hospitalized? No Yes
If yes, please list reason/when: _____
_____

Has the patient had any serious illness of the following?

Fuente de Informacion
Medico de cabecera: _____
Medico que lo remiti/Clinica: _____
Diagnostico: _____
Person que suministra la informacion: _____
Relacion con el paciente: _____
Idioma que habla: _____

Motivo principal de la consulta
Motivo de la consulta: _____
_____

Como se entero acerca de nosotros
_____

Antecedentes
Estan sus vacunas AL DIA? No Yes
Es el paciente alergio a algun medicamento? No Yes
Si la repuesta es si, indique a cuales: _____
Especifique la reaccion: _____
Es el paciente alergico al LATEX? No Yes
Toma el paciente medicamentos recetados?
Medicamentos Dosis Cuantas veces al dia
_____
_____
_____
_____
Cual fue el peso del paciente al nacer?
_____libras ____onzas
Tuvo el paciente un macimiento premature? No Yes
Ha padecido el paciente problemas respiratorias? No Yes
Ha tenido el paciente icteria (color amarillento) No Yes
Se le han hecho al paciente transfusions de sangre? No Yes
Estuvo el paciente en terapia intensice al nacer? No Yes
Presento el paciente comlicaciones durante el nacimiento?
Si la repuesta es si, por favor explique: _____
_____

Ha side el paciente alguna vez hospitalizado?
Si la repuesta es si, por favor indique el motive y cuando oscurrio: _____
Se ha sometido al paciente a alguna operacion?
Si la repuesta es si, por favor indique que tipo y cuando oscurrio:_____
Ha padecio el paciente alguna de las siguientes enfermedades grave?