

# Harold Perlaza, D.D.S

## PATIENT HISTORY & INFORMATION (for children up to age 18)

### MEDICAL HISTORY

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle Initial

Physician's Name: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

Last consultation/visit with a physician? \_\_\_\_\_ Reason: \_\_\_\_\_

Last physical examination? \_\_\_\_\_ Results: \_\_\_\_\_

Been a patient in a hospital in the past 5 years:  Yes  No Reason: \_\_\_\_\_

Had any serious illness or operations?  Yes  No Type: \_\_\_\_\_

Ever had blood transfused?  Yes  No When: \_\_\_\_\_

Have now, or ever had, any of the following (Please check and describe fully under remarks):

- |                                    | Yes                      | No                       |                                | Yes                      | No                       |                               | Yes                      | No                       |
|------------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| 1 Heart Disease                    | <input type="checkbox"/> | <input type="checkbox"/> | 14. Persistent Swollen Glands  | <input type="checkbox"/> | <input type="checkbox"/> | 27. Jaundice                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 High Blood Pressure              | <input type="checkbox"/> | <input type="checkbox"/> | 15. Psychiatric Treatment      | <input type="checkbox"/> | <input type="checkbox"/> | 28. Hepatitis, A or B         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Blood Disorder — Anemia          | <input type="checkbox"/> | <input type="checkbox"/> | 16. Arthritis                  | <input type="checkbox"/> | <input type="checkbox"/> | 29. Chronic Headaches         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Rheumatic Fever                  | <input type="checkbox"/> | <input type="checkbox"/> | 17. Night Sweats               | <input type="checkbox"/> | <input type="checkbox"/> | 30. Ringing in the Ears       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Heart Murmur                     | <input type="checkbox"/> | <input type="checkbox"/> | 18. Persistent Cough           | <input type="checkbox"/> | <input type="checkbox"/> | 31. Allergies                 |                          |                          |
| 6 Artificial Joints or Devices     | <input type="checkbox"/> | <input type="checkbox"/> | 19. Tumor History              | <input type="checkbox"/> | <input type="checkbox"/> | a. Penicillin                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Heart Valve Damage or Surgery    | <input type="checkbox"/> | <input type="checkbox"/> | 20. Chemotherapy               | <input type="checkbox"/> | <input type="checkbox"/> | b. Other Antibiotics          | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Chest Pain                       | <input type="checkbox"/> | <input type="checkbox"/> | 21. Radiation Treatment        | <input type="checkbox"/> | <input type="checkbox"/> | c. Codeine, Aspirin           | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 Thyroid Disease, Hyperthyroidism | <input type="checkbox"/> | <input type="checkbox"/> | 22. Immune System Disorders    | <input type="checkbox"/> | <input type="checkbox"/> | d. Local Anesthetic, Novocain | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Diabetes                        | <input type="checkbox"/> | <input type="checkbox"/> | 23. AIDS, ARC or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | e. Latex                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 Stroke                          | <input type="checkbox"/> | <input type="checkbox"/> | 24. Sinus Trouble              | <input type="checkbox"/> | <input type="checkbox"/> | f. Others                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 Epilepsy or Seizures            | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ulcers                     | <input type="checkbox"/> | <input type="checkbox"/> | 32. Asthma                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 Fainting                        | <input type="checkbox"/> | <input type="checkbox"/> | 26. Liver or Kidney Disease    | <input type="checkbox"/> | <input type="checkbox"/> | 33. Tuberculosis, Emphysema   | <input type="checkbox"/> | <input type="checkbox"/> |

Had excessive bleeding requiring treatment?  Yes  No

Taking any medicines, drugs or pills?  Yes  No If yes, what? \_\_\_\_\_

Have any disease, condition or problem not listed above? \_\_\_\_\_

### DENTAL HISTORY

Does or has your child:

- Experienced any unfavorable reactions to previous dental treatment?  Yes  No
- Have gums that bleed when brushed?  Yes  No
- Chew properly and without pain?  Yes  No
- Brush teeth daily?  Yes  No
- Is Fluoride being taken daily?  Yes  No
- Had or need orthodontic treatment?  Yes  No
- Have stains or discoloration on teeth?  Yes  No
- Require premedication prior to dental treatment?  Yes  No
- Name of former dentist: \_\_\_\_\_ Date of last exam: \_\_\_\_\_
- Please note any special dental concerns that bring you to our office: \_\_\_\_\_

Parent (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

