Gordon R. Ediger, DDS

Parkway Plaza Dental
13450 Roe Avenue
Leawood, KS

Patient (Child's) Name _____

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Name of your child's pediatrician or family physician_____

Is your child under the care of a physician now? YES NO

Has your child ever been hospitalized or had a major operation? YES NO

Has your child ever had a serious head or neck injury? YES NO

Is your child taking any medications, pills or drugs? YES NO
If yes, please list _____

Is your child on a special diet? YES NO
If yes, please describe_____

Is your child allergic to any of the following?

Aspirin Penicillin Amoxicillin Codeine Latex Local Anesthetics Other
If other, please list_____

Does your child have or had any of the following?

AIDS/HIV Positive	___	Cortisone Medicine	___	Hemophilia	___	Renal Dialysis	___
Alzheimer's Disease	___	Diabetes	___	Hepatitis A	___	Rheumatic Fever	___
Anaphylaxis	___	Drug Addiction	___	Hepatitis B or C	___	Rheumatism	___
Anemia	___	Easily Winded	___	Herpes	___	Scarlet Fever	___
Angina	___	Emphysema	___	High Blood Pressure	___	Shingles	___
Arthritis/Gout	___	Epilepsy or Seizures	___	Ives r Rash	___	Sickle Cell Disease	___
Artificial Heart Valve	___	Excessive Bleeding	___	Hypoglycemia	___	Sinus Trouble	___
Artificial Joint	___	Excessive Thirst	___	Irregular Heartbeat	___	Spina Bifida	___
Asthma	___	Fainting Spells/Dizziness	___	Kidney Problems	___	Stomach/Intestinal Disease	___
Blood disease	___	Frequent Cough	___	Leukemia	___	Stroke	___
Blood Transfusion	___	Frequent Diarrhea	___	Liver Disease	___	Swelling of Limbs	___
Breathing Problem	___	Frequent Headaches	___	Low Blood Pressure	___	Thyroid Disease	___
Bruise Easily	___	Genital Herpes	___	Lung Disease	___	Tonsillitis	___
Cancer	___	Glaucoma	___	Mitral Valve Prolapse	___	Tuberculosis	___
Chemotherapy	___	Hayfever	___	Pain in Jaw Joints	___	Tumors or Growths	___
Chest Pains	___	Heart Attack/Failure	___	Parathyroid Disease	___	Ulcers	___
Cold Sores/Fever Blisters	___	Heart Murmur	___	Psychiatric Care	___	Venereal Disease	___
Congenital Heart Disorder	___	Heart Pace Maker	___	Radiation Treatments	___	Yellow Jaundice	___
Convulsions	___	Heart Trouble/Disease	___	Recent Weight Loss	___		

Has your child ever had any serious illness not listed above? YES NO
If yes, please describe _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Guardian_____ Date _____