Dr. Christine M. Reardon, D.M.D., P.C.
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703-778-7610

Patient Health History

□ YES □ NO Is your child generally healthy? Date of last physical:_____
Physician name and phone #:_____

□ YES □ NO Is your child currently taking any medications? Please list medications and reason:_____

□ YES □ NO Has your child ever been hospitalized or had any surgeries:
Date & Reason:_____

□ YES □ NO Was your child ever diagnosed with any disease, illness or syndrome:
_____

□ YES □ NO Were there any problems at birth?_____

□ YES □ NO Has your physician advised your child to take antibiotics prior to dental treatment?_____

□ YES □ NO Does your child have any allergies?_____

Please check if your child has ever been diagnosed or treated for the following:

□ Heart Disease
□ Heart Murmur
□ Rheumatic or Scarlet Fever
□ Mitral Valve Prolapse
□ Bleeding Disorder
□ Blood Transfusion
□ Anemia
□ Sickle Cell Disease
□ Hemophilia
□ HIV
□ Hearing / Vision Problems
□ Skin Problems
□ Cold / Canker Sores
□ Asthma
□ Tuberculosis
□ Sinus Problems
□ Diabetes
□ Stomach or Intestinal Problems
□ Acid Reflux
□ Liver Problems
□ Eating Disorders
□ Hepatitis
□ Jaundice
□ Kidney Problems
□ Epilepsy or Seizures
□ Sensory Disorders
□ Down's Syndrome
□ Autism
□ Learning Disability
□ Physical Disability
□ ADHD
□ Personality / social disorder
□ Congenital Birth Defect
□ Muscular Dystrophy
□ Muscular Weakness
□ Cleft Lip / Palate
□ Other

Please elaborate on checked items:_____
_____
_____

_____ _____
Signature of Parent or Guardian Date