

**TO ASSIST US IN KEEPING YOUR RECORDS UP TO DATE, PLEASE FILL THE FOLLOWING OUT COMPLETELY**

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age : \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zipcode

Home Phone: \_\_\_\_\_ Join Our Email List: \_\_\_\_\_

Cell Phone: Mom \_\_\_\_\_ Dad: \_\_\_\_\_

Father's Info: Employer \_\_\_\_\_ Phone# \_\_\_\_\_ Insurance: \_\_\_\_\_

Mother's Info: Employer \_\_\_\_\_ Phone# \_\_\_\_\_ Insurance: \_\_\_\_\_

1. Has your child's medical history changed since your last visit? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_

2. Has your child ever received a blood transfusion or blood products? Yes \_\_\_ No \_\_\_ When \_\_\_\_\_

3. Does your child have allergies or sensitivities to any drugs or medications and /or allergies to latex rubber?  
 Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

4. Is your child taking any medications at present? Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

5. Is your child presently being seen by a physician for a particular problem?  
 Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

6. Are there any areas in your child's mouth that cause pain or discomfort?  
 Yes \_\_\_ No \_\_\_ Where? \_\_\_\_\_ How Long? \_\_\_\_\_

7. Are there any questions about your child's dental health that we can answer today?  
 Yes \_\_\_ No \_\_\_ If so what? \_\_\_\_\_

In compliance with Cal-OSHA Title 8, Section 5199, dental facilities must pre-screen patients for aerosol transmissible diseases (ATD). In our office we use this form to pre-screen a patient before any dental procedure is performed to determine whether the patient may present an ATD exposure risk. **Does your child have:**

A history of Tuberculosis?	Yes ___ No ___	Vomiting or Diarrhea:	Yes ___ No ___ How Long? _____
Bloody Sputum?	Yes ___ No ___	Fever:	Yes ___ No ___ How Long? _____
Night Sweats	Yes ___ No ___	Fatigue	Yes ___ No ___
Unexplained weight loss	Yes ___ No ___	Malaise	Yes ___ No ___
Runny Nose:	Yes ___ No ___ How Long? _____	Body Aches:	Yes ___ No ___ How Long? _____
Headache:	Yes ___ No ___ How Long? _____	Sore Throat:	Yes ___ No ___ How Long? _____
Severe coughing spasms:	Yes ___ No ___ How Long? _____	Fever w/respiratory symptoms:	Yes ___ No ___ How Long? _____
Painful, swollen glands:	Yes ___ No ___ How Long? _____	Nausea:	Yes ___ No ___ How Long? _____
Skin rash, blisters:	Yes ___ No ___ How Long? _____	Stiff neck, mental changes:	Yes ___ No ___ How Long? _____
Symptoms of Tuberculosis?	Productive cough (> 3 weeks) Yes ___ No ___		

Flu or other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis? \_\_\_\_\_

If yes to any of the above, please explain: \_\_\_\_\_

Chronic Respiratory Diseases (NOT ATD and not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199: Does your child have:

Asthma?	Yes ___ No ___	Chronic upper airway cough syndrome "postnasal drip"?	Yes ___ No ___
Allergies?	Yes ___ No ___	Gastroesophageal reflux disease (GERD)?	Yes ___ No ___
Chronic obstructive pulmonary disease?	Yes ___ No ___	Bronchitis?	Yes ___ No ___
Emphysema?	Yes ___ No ___	Dry cough from ACE inhibitors?	Yes ___ No ___

Sign: \_\_\_\_\_  
 (Parent/legal guardian)