Medical History Supplemental Form

Patient's name:____________________________________ DOB:________________

Guardian's name:____

	Yes	No
Has your child had a fever or felt feverish in the past 14 days?		
Does your child have an active cough today?		
Is your child having any difficulty breathing? Short of breath?		
Has your child taken Tylenol or Ibuprofen in the past 48 hours?		
Does your child have any flu-like symptoms? If yes, please circle: (fever, chills, cough, sore throat, muscle or body aches, fatigue/tiredness, upset stomach, vomiting, diarrhea)		
Has your child recently experienced a loss of smell or taste?		
Have you or your child been in contact with anyone confirmed positive with COVID-19?		
Have you or your child recently been in contact with anyone who has had the following symptoms: fever, cough, shortness of breath, loss of taste/smell, flu-like symptoms?		

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

Signature: ____ **Date:**________________