CHILD HEALTH HISTORY

Patient Name: Birth Date: Date Created:

For the following questions, please (X) whichever applies. Your answers are for our records only and will be k ept confidential in accordance with applicable laws. This inform

DENTAL INFORMATION

Does your child have any dental problems? Yes No If yes

Does your child brush his/her teeth daily? Yes No

Do your child's gums bleed when they brush? Yes No If yes

Does your child drink soda? How much per day? Yes No If yes

Are your child's teeth sensitive to:

Hot	Yes No	Cold	Yes No	Sweets	Yes No	Pressure	Yes No

Do you have:

City Water	Yes No	Well Water	Yes No

Does your child suck his/her thumb? Yes No

Has your child had orthodontic (braces) treatment? Yes No

Has your child had a bad experience at a dental office? Please explain. Yes No If yes

MEDICAL INFORMATION

Is your child in good health? Yes No

Is your child currently under the care of a physician? If yes, what are the condition(s) being treated? Yes No If yes

Date of last physical exam: omment

Physicians Name: omment

Physicans Phone Number: omment

Has your child had any hospital stays or sugeries? If yes, what was the illness or problem? Yes No If yes

Does your child us an asthma inhaler? Yes No

When was the last time it was used? omment

Has a doctor or dentist recommended that your child take antibiotics prior to dental treatment? Yes No If yes

Is your child taking any medications, pills or drugs? Yes No If yes

ALLERGIES

Is your child allergic to or have they had a reaction to: Please check all that apply.

☐ Aspirin	☐ Penicillin or other Antibiotics	☐ Codeine or other Narcotics	☐ Latex
☐ Sulfa Drugs	☐ Local Anesthetics (Novacaine)	☐ Pain Medications/Ibuprofen	☐ Iodine

Does your child have any other allergies not listed above? Please list. Yes No If yes

MEDICAL HISTORY

Does your child have, or have ever had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Attention Deficit/ADHD ○ Yes ○ No	Eating Disorder ○ Yes ○ No		

Has your child ever had any serious illness not listed above? ○ Yes ○ No If yes

Note: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understood the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form. Missed appointments and late cancellations may incur a $50 charge.

Signature of Patient, Parent or Guardian:

X

Date:_____