Child Health / Dental History Form

Date of Birth: _____

Patient name: _____ Nickname: _____

Parent's / Guardian's name: _____ Relationship: _____

School: _____ Hobbies/Pets: _____

Have you (the parent/guardian) or the patient had any of the following diseases or problems? .....❑ Yes ❑ No

1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Please list the name and phone number of the child's primary care physician:

Name of Physician: _____Phone: _____
Date of Last Medical Exam:_____

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Arthritis	❑ Asthma	❑ Bladder	❑ Bleeding disorders
❑ Bones/Joints	❑ Cancer	❑ Cerebral Palsy	❑ Chicken Pox	❑ Chronic Sinusitis
❑ Diabetes	❑ Ear Aches	❑ Epilepsy	❑ Fainting	❑ Growth Problems
❑ Hearing	❑ Heart	❑ Hepatitis	❑ HIV +/AIDS	❑ Immunizations
❑ Kidney	❑ Latex allergy	❑ Liver	❑ Measles	❑ Mononucleosis
❑ Mumps	❑ Pregnancy (teens)	❑ Rheumatic fever	❑ Seizures	❑ Sickle cell
❑ Thyroid	❑ Tobacco/Drug Use	❑ Tuberculosis	❑ Venereal Disease	❑ ADHD

❑ Breathing or sleeping concerns? (i.e. sleep apnea, snoring, sinus) _____
❑ Other_____

Allergies or bad reaction to the following:

❑ Ibuprofen, acetaminophen ❑ Penicillin, amoxicillin ❑ Fluoride ❑ Local anesthetic
❑ Metals ❑ Latex ❑ Nuts ❑ Fruit ❑ Other: _____

Current Medications: Prescription and/or over the counter or vitamin supplements:

Name	Purpose

NEXT PAGE FOR HISTORY……

Child's Medical History

	Yes	No
1. Is the child taking any **prescription** and/or **over the counter medications** or vitamin supplements at this time?	1. ❑	❑
2. Has the child ever been hospitalized?	2. ❑	❑
If yes, when: _____ Please describe: _____		
3. Has the child ever had or have a serious illness?	3. ❑	❑
If yes, when: _____ Please describe: _____		
4. Does the child have a history of any other illnesses?	4. ❑	❑
If yes, please list: _____		
5. Does the child have any inherited problems?	5. ❑	❑
If yes please describe: _____		
6. Does the child have any speech difficulties? _____	6. ❑	❑
7. Is the child physically, mentally, or emotionally impaired? _____	7. ❑	❑
8. Does the child experience excessive bleeding when cut? _____	8. ❑	❑

At what age did the child **stop** bottle feeding? Age _____ Breast feeding? Age _____

How would you describe the child's eating habits? _____

Child's Dental History

9. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit?	9. ❑	❑
Date: _____ X-rays taken? _____		
10. Has the child ever received a general anesthetic?	10. ❑	❑
11. Has the child had any **problem**s with dental treatment in the past?	11. ❑	❑
12. Has the child ever had dental radiographs (x-rays)	12. ❑	❑
13. Has the child ever suffered any injuries to the mouth, head or teeth?	13. ❑	❑
14. Has the child had any problems with the eruption or shedding of teeth?	14. ❑	❑
15. Has the child had any orthodontic treatment?	15. ❑	❑
16. What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
17. Does the child take fluoride supplements?	17. ❑	❑
18. Is fluoride toothpaste used?	18. ❑	❑
19. Does the child suck his/her thumb, fingers or pacifier?	19. ❑	❑
20. Does child participate in active recreational activities?	20. ❑	❑

21. How many times are the child's teeth brushed per day? _____ Morning / Night

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand 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 the completion of this form.

Parent's/Guardian's Signature _____

Date _____

Office use only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by: _____ Date: _____