

Child Health/Dental History Form

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth																																				
Parent's/Guardian's Name			Relationship to Patient																																					
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>																																								
Phone <small>Home Work</small>			Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>																																					
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?																																								
<table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> HIV +/-AIDS</td> <td><input type="checkbox"/> Mononucleosis</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Immunizations</td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/> Tobacco/Drug Use</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> Growth Problems</td> <td><input type="checkbox"/> Kidney</td> <td><input type="checkbox"/> Pregnancy (teens)</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Bladder</td> <td><input type="checkbox"/> Chronic Sinusitis</td> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Latex allergy</td> <td><input type="checkbox"/> Rheumatic fever</td> <td><input type="checkbox"/> Venereal Disease</td> </tr> <tr> <td><input type="checkbox"/> Bleeding disorders</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Liver</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Bones/Joints</td> <td><input type="checkbox"/> Ear Aches</td> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Measles</td> <td><input type="checkbox"/> Sickle cell</td> <td></td> </tr> </table>					<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____	<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid																																			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use																																			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis																																			
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease																																			
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____																																			
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell																																				
Name of Physician _____			Phone _____																																					

- | | Yes | No |
|--|------------------------------|--------------------------|
| 1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?
If yes, please list: _____ | 1. <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ | 2. <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ | 3. <input type="checkbox"/> | <input type="checkbox"/> |
| 4. How would you describe the child's eating habits? _____ | | |
| 5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ | 5. <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the child ever been hospitalized? | 6. <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the child have a history of any other illnesses? If yes, please list: _____ | 7. <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the child ever received a general anesthetic? | 8. <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the child have any inherited problems?..... | 9. <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does the child have any speech difficulties?..... | 10. <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the child ever had a blood transfusion?..... | 11. <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is the child physically, mentally, or emotionally impaired?..... | 12. <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does the child experience excessive bleeding when cut?..... | 13. <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is the child currently being treated for any illnesses?..... | 14. <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____ | 15. <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has the child had any problem with dental treatment in the past? | 16. <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has the child ever had dental radiographs (x-rays) exposed? | 17. <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has the child ever suffered any injuries to the mouth, head or teeth? | 18. <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has the child had any problems with the eruption or shedding of teeth? | 19. <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has the child had any orthodontic treatment? | 20. <input type="checkbox"/> | <input type="checkbox"/> |
| 21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water | | |
| 22. Does the child take fluoride supplements? | 22. <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Is fluoride toothpaste used?..... | 23. <input type="checkbox"/> | <input type="checkbox"/> |
| 24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____ | 24. <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does the child suck his/her thumb, fingers or pacifier?..... | 25. <input type="checkbox"/> | <input type="checkbox"/> |
| 26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____ | | |
| 27. Does child participate in active recreational activities?..... | 27. <input type="checkbox"/> | <input type="checkbox"/> |

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 _____

Comments _____

Medical Alert Premedication Allergies Anesthesia Reviewed by _____
Date _____