CHILD HEALTH HISTORY

In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.

Date: Child's Name:
Birthdate: Age: Gender: Male ◯ Female ◯ Nickname:
Father's Name: Mother's Name: Legal Guardian's Name:

Child's Physician: Phone:
Date of Last Physical Examination: How is your child's general health?
Has your child had any serious illness and/or hospitalization? Yes ◯ No ◯
If yes, describe and date: _____
Is your child receiving any medication at this time? Yes ◯ No ◯
Medication name and reason:
Has your child ever had an allergic reaction or sensitivity reaction to the following:
Dental Anesthetics ☐ Antibiotics ☐ Food ☐ Drugs ☐ Latex ☐ Nickel ☐ None ☐
Please name and describe reaction:
Has your child ever received a blow or injury to his head or teeth? Yes ◯ No ◯ If yes, describe: _____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS?

1) ADD/ ADHD ◯Y ◯N	15) DIABETES ☐TYPE I ☐TYPE II ◯Y ◯N	29) PREGNANT ◯Y ◯N
2) ADOPTED ◯Y ◯N	16) DOWN SYNDROME ◯Y ◯N	30) PSYCHIATRIC PROBLEMS ◯Y ◯N
3) ANEMIA ◯Y ◯N	17) EMOTIONAL PROBLEMS ◯Y ◯N	31) RADIATION THERAPY/ CHEMO ◯Y ◯N
4) ANXIETY ◯Y ◯N	18) EPILEPSY ◯Y ◯N	32) RHEUMATIC FEVER ◯Y ◯N
5) ASTHMA ◯Y ◯N	19) G-TUBE FEEDING ◯Y ◯N	33) SEIZURES ◯Y ◯N
6) AUTISM ◯Y ◯N	20) HEARING LOSS/IMPAIRMENT ◯Y ◯N	34) SICKLE CELL ANEMIA ◯Y ◯N
7) BLEEDING DISORDER ◯Y ◯N	21) HEART CONDITION ◯Y ◯N	35) SKIN DISORDERS ◯Y ◯N
8) CANCER TYPE: ◯Y ◯N	22) HEART MURMUR ◯Y ◯N	36) SLEEP APNEA ◯Y ◯N
9) CEREBRAL PALSY ◯Y ◯N	23) HEPATITIS ☐A ☐B ☐C ◯Y ◯N	37) SNORING ◯Y ◯N
10) CHRONIC EAR INFECTIONS ◯Y ◯N	24) HIV/AIDS ◯Y ◯N	38) SYNDROME (SPECIFY) _____
11) CLEFT LIP/ PALATE ◯Y ◯N	25) KIDNEY DISEASE ◯Y ◯N	_____
12) CYSTIC FIBROSIS ◯Y ◯N	26) LEARNING DISABILITIES ◯Y ◯N	39) Other
13) DELAYED SPEECH DEVELOPMENT ◯Y ◯N	27) LIVER DISEASE ◯Y ◯N	_____
14) DEVELOPMENTAL DELAY ◯Y ◯N	28) MUSCULAR DYSTROPHY ◯Y ◯N	_____

Comments:

Does your child have any habits we should know about, such as:
Poor Eating Habits ☐ Finger/Thumb Sucking ☐ Pacifier ☐ Bottles ☐ Nail Biting ☐ Other:

Family Dental History: Missing Teeth ☐ Extra Teeth ☐ Decay ☐ Underbite ☐ Overbite ☐ Jaw Surgery ☐
Other:

Does your child receive fluoride in: Drinking Water at Home Yes ◯ No ◯ By Prescription: Yes ◯ No ◯

Has your child had any unpleasant dental experiences? Yes ◯ No ◯

How can we help?

Date of last dental examination: Previous Dentist's Name:
Has your child ever had orthodontic treatment? Yes ◯ No ◯ When? Where
What is the nature of today's visit? Regular Exam ◯ Emergency ◯ State Problem: Other:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.