CHILD HEALTH QUESTIONNAIRE

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

Date ______/______/______

Child's Name ______________________ Nickname ______________________

Birthdate ______/______/______ Age _________ Sex _________

Father's Name ______________________ Mother'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? YES ○ NO ○ If yes, describe: ______________________

Has your child ever been hospitalized? YES ○ NO ○ For what reason? ______________________

Is your child receiving any medication at this time? YES ○ NO ○ If yes, describe: ______________________

Has your child ever had an allergic reaction to the following: Dental Anesthetics ○ Antibiotics ○ Food ○ Drugs ○ Latex ○

Please describe: ______________________

Has your child ever received a blow or injury to the head or teeth? YES ○ NO ○ Describe: ______________________

Has your child ever been treated with X-ray or radiation therapy? YES ○ NO ○

Has your child ever had any of the following conditions? *Please check:*

	YES	NO			YES	NO			YES	NO	
Heart Disease	○	○	Age ____	Hepatitis	○	○	Age ____	Hearing Problems	○	○	Age ____
Heart Murmur	○	○	Age ____	Aids or HIV	○	○	Age ____	TB (Tuberculosis)	○	○	Age ____
Rheumatic Fever	○	○	Age ____	Bleeding Problems	○	○	Age ____	Sickle Cell Anemia	○	○	Age ____
Diabetes	○	○	Age ____	Lung Disease	○	○	Age ____	*Circle* Disease *or* Trait			
Scarlet Fever	○	○	Age ____	Liver Disease	○	○	Age ____	Other *(Please describe):* ____			
Kidney Disease	○	○	Age ____	Learning Disability	○	○	Age ____	____			
Epilepsy	○	○	Age ____	Emotional Disturbance	○	○	Age ____	____			
Asthma	○	○	Age ____	Mononucleosis	○	○	Age ____	____			

Does your child have any habits we should know about, such as: Poor Eating Habits ○ Thumb Sucking ○ Pacifier ○ Bottles ○

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 ______/______/______

Has your child ever had orthodontic treatment? YES ○ NO ○ When? ____________

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.

Signature of Parent or Guardian: ______________________

Signature of Doctor/Staff: ______________________