



Child Health / Dental History

Patient's Name: _____ Nickname: _____ Date of Birth: _____
 Parent's/Guardian's Name: _____ Relationship to Patient: _____
 Address: _____ PO Box or Mailing Address _____ City _____ State _____ Zip Code _____
 Phone: () _____ () _____ Sex: M F Non binary
 Home _____ Work _____

Have you (the parent/guardian) or the patient had any of the following diseases or problems:
 1. Active Tuberculosis 2. Persistent cough greater than a three-week duration 3. Cough that produces blood? Yes No
 If you answer yes to any of the three items above, please stop and return this form to the receptionist.

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

<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"/> Healthy	<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	

Please list the name and phone number of the child's physician: Physician _____ Phone _____ - _____ - _____
 Date of last physical exam: _____

Child's History

	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? _____	4. <input type="checkbox"/>	<input type="checkbox"/>
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 the dentist? If not, what was the date of the last dental 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 a dental radiographs (x-rays) exposed? If yes, Date Exposed or X-rays taken: _____	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	21. <input type="checkbox"/>	<input type="checkbox"/>
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. Do you floss your child's teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often: _____	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age: _____ Breastfeeding? Age: _____	26. <input type="checkbox"/>	<input type="checkbox"/>
27. Does child participate in active recreational activities?	27. <input type="checkbox"/>	<input type="checkbox"/>
28. Does the child such his/her thumb, fingers or pacifier?	28. <input type="checkbox"/>	<input type="checkbox"/>
29. What is the reason for your visit today?	29. <input type="checkbox"/>	<input type="checkbox"/>
30. How often does your child visit the dentist?	30. <input type="checkbox"/>	<input type="checkbox"/>
31. Name of former Dentist: _____	31. <input type="checkbox"/>	<input type="checkbox"/>

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 _____

For Completion by dentist
 Comments: _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by: _____ Date: _____