

# Child Health/Dental History Form

Patient's Name LAST FIRST INITIAL			Nickname	Date of Birth
Parent's/Guardian's Name			Relationship to Patient	
Address P.O. BOX OR MAILING ADDRESS		CITY	STATE	ZIPCODE
Phone HOME WORK			Patient's Sex <input type="checkbox"/> F <input type="checkbox"/> M	

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.**

**Has the child had any history of, difficulty with, or diagnosis of any of the following:**

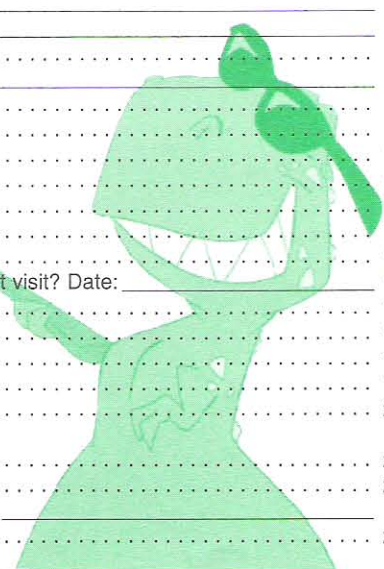
- |   |  |  |  |  |   |
|---|--|--|--|--|---|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Mononucleosis     | <input type="checkbox"/> Thyroid          |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Cerebral Palsy    | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Kidney        | <input type="checkbox"/> Mumps             | <input type="checkbox"/> Tobacco/Drug Use |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> Hearing         | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Pregnancy (teens) | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Bladder            | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Heart           | <input type="checkbox"/> Liver         | <input type="checkbox"/> Rheumatic fever   | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Mastoiditis   | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Bones/Joints       | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> HIV +/-AIDS     | <input type="checkbox"/> Measles       | <input type="checkbox"/> Sickle cell       |   |

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

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

## CHILD'S HISTORY

- |  | Yes                          | No                       |
|--|------------------------------|--------------------------|
| 1. Is the child taking any medications 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 |                              |                          |
| 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? _____  |                              |                          |
| 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 _____   |                              |                          |



**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 on parent/guardian and patient interview concerning health history \_\_\_\_\_

Significant findings from questionnaire or oral interview \_\_\_\_\_

Dental management considerations \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only:**  Medical Alert  Premedication  Allergies  Anesthesia Reviewed by \_\_\_\_\_ Date \_\_\_\_\_