CHILD'S HEALTH HISTORY

GENERAL INFORMATION

Child's name:_____Nickname:_____

Date of Birth:_____ Describe child's temperament:_____
Mo/day/year

Name of parent/guardian filling out this form:_____

Who is/are the custodial parent(s):_____

DENTAL

Previous dentist:_____ _____

Is there a particular concern you would like examined today? Yes No Explain:_____

Date of last dental exam:_____ Cleaning:_____ Dental Radiographs:_____

Has in the past or is now nursing or bottle feeding at night? Yes No Drink water from the tap? Yes No Bottled water? Yes No

Has your child had any negative dental or medical experiences? Yes No Explain:_____

Has your child had any TMJ(Jaw) problems? Yes No Thumb sucking? Yes No Teeth Grinding? Yes No Other oral habits? Yes No

Is your child taking fluoride drops or tablets? Yes No Since when?_____ How much and when?_____

MEDICAL

Child's physician:_____Tel:_____

Address:_____ Date of last exam:_____

Has your child had or he/she now have any of the following diseases or conditions? If YES, please circle which condition applies.

1. Heart disease, murmurs or rheumatic fever?	Yes No	14. Liver (hepatitis), GI, Thyroid problems?	Yes No
2. Low or high blood pressure?	Yes No	15. Kidneys, endocrine, problems with vision or hearing?	Yes No
3. Fever, sinusitis, seasonal allergies?	Yes No	16. Asthma? Treatment: _____	Yes No
4. Hospitalized: Injuries? _____ Date(s)?:_____	Yes No	17. Other breathing problems/diseases (lungs, TB)?	Yes No
Surgeries? _____ Date(s)?:_____	Yes No	18. Epilepsy, seizures, or fainting?	Yes No
5. Cold sores? Canker sores?	Yes No	19. Learning or behavior problems?	Yes No
6. Diabetes, arthritis?	Yes No	20. Sore throat, tonsils, ear aches/infections?	Yes No
7. Emotional problems?	Yes No	21. Venereal disease or other serious infections?	Yes No
8. Childhood diseases?	Yes No	22. Bleeding problems or diseases of the blood?	Yes No
9. Cancer, tumors, other growths?	Yes No	23. Tobacco use (any form)?	Yes No
10. Blood transfusions? Date(s): _____	Yes No	24. Frequent/recurrent headaches or migraines?	Yes No
11. Radiation or chemotherapy? Date(s): _____	Yes No	25. Other?	Yes No
12. Allergies or reactions to medications?	Yes No	Note: _____	
Reactions to:		26. Medicines (prescription or over-the-counter, vitamins etc):	Yes No
Aspirin or pain medications?	Yes No	_____	Yes No
Food(s)?: _____	Yes No	27. Is your child adopted?	Yes No
Antibiotics?: _____	Yes No	28. Does he/she know?	Yes No
Latex, dental anesthetics?	Yes No	29. Chemical dependencies?	Yes No
Other (preservatives, flavorings)? _____	Yes No	30. Congenital birth defects? Note:_____	Yes No
13. Immunological problems or diseases? (Leukemia, AIDS//HIV positive, other)	Yes No	31. Developmental delay/ mental challenges?	Yes No

FEMALE PATIENTS

1. Is there any chance that you might be pregnant? Yes No
2. Are you taking birth control pills? Yes No

Signature of Parent/Guardian **Today's Date**