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**HEALTH QUESTIONARE**

PLEASE COMPLETE THE FOLLOWING QUESTIONS. THIS INFORMATION WILL HELP US IN PERFORMING OPTIMUM DENTAL TREATMENT FOR YOUR CHILD. YOUR ANSWERS WILL BE CONSIDERED CONFIDENTIAL AND WILL BECOME A PART OF YOUR CHILD'S PERMANENT DENTAL RECORD.

**CHILD'S NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS AND THEN EXPLAIN ALL "YES" ANSWERS UNDER COMMENTS AT BOTTOM OF PAGE.**

- 1. DOES THIS CHILD HAVE A CURRENT MEDICAL PROBLEM? YES NO
- 2. IS THIS CHILD TAKING ANY MEDICATION NOW? YES NO
- 3. HAS THIS CHILD EVER BEEN SERIOUSLY ILL OR HOSPITALIZED? YES NO
- 4. HAVE YOU EVER BEEN TOLD BY A PHYSICIAN THAT THIS CHILD HAS A HEART MURMUR? YES NO
- 5. HAVE YOU EVER BEEN TOLD BY A PHYSICIAN THAT THIS CHILD HAS HEPATITIS? YES NO
- 6. DOES THIS CHILD HAVE ASTHMA OR HAY FEVER? (CIRCLE ONE)
- 7. DOES THIS CHILD HAVE HIVES OR SKIN RASH? (CIRCLE ONE)
- 8. IS THIS CHILD PHYSICALLY OR MENTALLY CHALLENGED? YES NO

9. HAS THIS CHILD EVER HAD ANY HISTORY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY?
- |                                    |                               |
|------------------------------------|-------------------------------|
| RHEUMATIC FEVER                    | HEART TROUBLE                 |
| ARTHRITIS (JOINT PAIN OR SWELLING) | JAUNDICE (YELLOW SKIN & EYES) |
| CONVULSIONS (SEIZURES) , EPILEPSY  | BLEEDING DISORDERS            |
| DIABETES                           | H.I.V.                        |
| TUBERCULOSIS                       | KIDNEY OR LIVER INVOLVEMENT   |
| SCARLET FEVER                      | BLISTERS OR COLD SORES        |
| HEPATITIS                          | OTHER _____                   |
| ATTENTION DEFICIT( ADHD )          |                               |

10. HAS THIS CHILD EVER EXPERIENCED AN UNUSUAL REACTION (ALLERGY OR SENSITIZATION) TO ANY

OF THE FOLLOWING MEDICINES?  
YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, PLEASE CIRCLE THE ONE BELOW:

- |                           |  |
|---------------------------|--|
| ASPRIN                    | DENTAL, LOCAL ANESTHETICS (USED TO PUT TEETH TO SLEEP) |
| PENICILLIN                |  |
| SULFONAMIDES (SULFA)      | OTHER _____  |
| ATARAXICS (TRANQUILIZERS) | _____  |

11. DOES THIS CHILD HAVE PROBLEMS WITH EXTENSIVE BLEEDING WHEN HE SCRATCHES OR CUTS HIMSELF? YES \_\_\_\_\_ NO \_\_\_\_\_

12. WHEN DID THIS CHILD LAST HAVE A COMPLETE PHYSICAL EXAMINATION?  
DATE: \_\_\_\_\_ REASON \_\_\_\_\_

13. WHO IS THE PEDIATRICIAN OR FAMILY PHYSICIAN FOR THIS CHILD? \_\_\_\_\_

**COMMENTS: EXPLANATIONS MUST BE GIVEN FOR EACH "YES" ANSWER**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TO BE COMPLETED AFTER EXAMINATION:**

I AUTHORIZE THE ATTENDING DENTIST TO COMPLETE ALL NECESSARY TREATMENT THAT WAS PLANNED AND DISCUSSED WITH ME.

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_