VITEK FAMILY DENTISTRY, P.C. ▪ ALEXA M. VITEK D.D.S. ▪ 13173 SCHAVEY ROAD ▪ DEWITT, MI 48820 ▪ 517-277-2000

CHILD HEALTH HISTORY

PERSONAL

First Name_____ Last Name_____ MI_____ M / F Birth Date _____

Nickname (if any)_____ Child's Interests/Hobbies_____

Mother's Full Name_____ Father's Full Name_____

MEDICAL HISTORY

Has your child had any of the following medical conditions: *Please circle (Y) Yes or (N) No*

Allergies to medications or food	Y	N	Hepatitis	Y	N
Asthma or lung problems	Y	N	High Fevers	Y	N
Attention Deficit Disorder	Y	N	HIV+/AIDS	Y	N
Cancer	Y	N	Hospital Stays/Operations	Y	N
Convulsions or Epilepsy	Y	N	Sickle Cell Disease	Y	N
Diabetes	Y	N	Thyroid Disease	Y	N
Fainting Spells/Dizziness	Y	N	Tuberculosis (TB)	Y	N
Handicaps or Disabilities	Y	N	Blindness	Y	N
Heart Defect (congenital)	Y	N	Other conditions/illnesses not listed above:		
Hemophilia or Abnormal Bleeding	Y	N	_____		

If you answered *yes* to any of the above, please explain:_____

_____

Is your child currently taking any medications? Yes No If *yes*, please list:_____

Have you been told by a physician that your child requires antibiotics prior to dental treatment? Yes No

DENTAL HISTORY

Has your child had any unfavorable experiences in a dental or medical office? Yes No

If *yes*, please explain:_____

Does your child have any dental problems/concerns presently? Yes No

If *yes*, please explain:_____

Has your child been to an orthodontist? Yes No If *yes*, name of orthodontist_____

How often does your child brush his/her teeth per day?_____ How often does your child floss?_____

Do you help him/her with brushing and flossing? Yes No Is your water at home fluoridated? Yes No

HABITS/DIET

Does your child have any of the following habits (or had in the past):

Thumb or finger sucking? Yes No Tooth grinding? Yes No

Does your child consume any of the following foods/beverages more than once per day?

Pop/Soda? Yes No Gatorade/Sports Drink? Yes No Fruit Juices? Yes No

Energy Drinks (i.e. Red Bull)? Yes No Sugary Snacks (candy, cookies, etc.) Yes No

I certify that I have read and understood the information on this form. The questions have been accurately answered to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dentist and staff of any changes to my child's health or medical status.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**