CHILD HEALTH HISTORY

First Name	<u>PERSONAL</u>									
Medical History Medical on orthodomism Medical conditions: Please circle (Y) Yes or (N) No Allergies to medications or food Y N Hepatitis Y N N Ashma or lung problems Y N High Fevers Y N N Ashma or lung problems Y N High Fevers Y N N N N N N N N N	First Name	Last N	ame		MI M / F Birth Date					
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 Ashma or lung problems Y N High Fevers Y N Athention Deficit Disorder Y N HIGH-YAIDS Y N Cancer Y N HIGH-YAIDS Y N ASHMA or lung problems Y N HIGH-YAIDS Y N HIGH-YAIDS Y N HIGH-YAIDS Y N HIGH-YAIDS Y N Cancer Y N N Hospital Stays/Operations Y N N Disbetes Y N N Thyroid Disease Y N N Thyroid Disease Y N N Handicaps or Disabilities Y N N Handicaps or Disabilities Y N Handicaps Y N N Handicaps or Disabilities Y N N Handicaps Y N N Handicaps or Disabilities Y N N Handicaps Y N N N Handicaps Y N	Nickname (if any)	Child's Interests/Hobbies								
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 Hall Hepatitis Hepatitis Y N Hall Hepatitis Y N Hall Hepatitis Y N Hall Handicapa or Disabilities Y N Hall Handicapas or Disabilities Y N Handicapas or Disabilities Y N Handicapas or Disabilities Y N Hall Handicapas or Disabilities Y N Handicapas or Disabilities Hemphilia or Abnormal Bleeding Y N Handicapas or Disabilities Hemphilia or Abnormal Bleeding Y N Handicapas or Disabilities Handicapas or Disability Handicapas Order Handicapas Order Handicapas Order Handicapas Handicapas Order Handicapas Order Handicapas Order Handicapas Handicapas Order Hand	Mother's Full Name				Father's Full Name					
Allergies to medications or food	MEDICAL HISTORY									
Asthma or lung problems	Has your child had any of the following	medical co	onditions:	Please c	ircle (Y) Yes	or (N) No				
Asthma or lung problems	Allergies to medications or food	Y	N		Hepatitis		Y	N		
Cancer	Asthma or lung problems				High Feve			N		
Convulsions or Epilepsy										
Diabetes Y N Tubroid Disease Y N N Thyroid Disease Y N N Hairling Spells/Dizziness Y N N Blindness Y N N Blindness Y N N N N N N N N N N N N N N N N N N										
Fainting Spells/Dizziness Y N Blindness (TB) Y N Blindness (TB) Y N N Ditter conditions/illnesses not listed above: Hemophilia or Abnormal Bleeding Y N N Other conditions/illnesses not listed above: Hemophilia or Abnormal Bleeding Y N N Other conditions/illnesses not listed above: Hemophilia or Abnormal Bleeding Y N N Other conditions/illnesses not listed above: Hemophilia or Abnormal Bleeding Y N N Other conditions/illnesses not listed above: Hemophilia or Abnormal Bleeding Y N N Other conditions/illnesses not listed above: Hemophilia or Abnormal Bleeding Y N N Other conditions/illnesses not listed above: Has 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 If yes, please explain: Does 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, name of orthodontist How often does your child brush his/her teeth per day? How often does your child floss? How often does your child floss? How often does your child floss? Yes No Is your water at home fluoridated? Yes No HABITS/DIET Does your child consume 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 Lecrtify 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		_								
Handicaps or Disabilities										
Heart Defect (congenital) Hemophilia or Abnormal Bleeding Y N Other conditions/illnesses not listed above: 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? 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 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										
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### Deep to lide by a physician that your child requires antibiotics prior to dental treatment? Yes No ### Deep Tall 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 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 ### It carrify 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 the providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dentist and the providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dentist and the providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dentist and the providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dentist and the providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dentist and the providence in the providence i	If you answered yes to any of the above,	please exp	olain:							
Has your child been to an orthodontist? Yes No If yes, name of orthodontist	DENTAL HISTORY Has your child had any unfavorable exp	eriences in	a dental o	or medica	l office?	Yes No	? Yes No			
Has your child been to an orthodontist? Yes No If yes, name of orthodontist	Does your child have any dental probler	ns/concern	s present	ly?	Yes	No				
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	If yes, please explain:									
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SIGNATURE OF PARENT/GUARDIAN DATE	understand that providing incorrect or incorstaff of any changes to my child's health or n	nplete inforn nedical stati	nation can			ild's health. It	t is my responsibilit			