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 ❑ F ❑ 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:

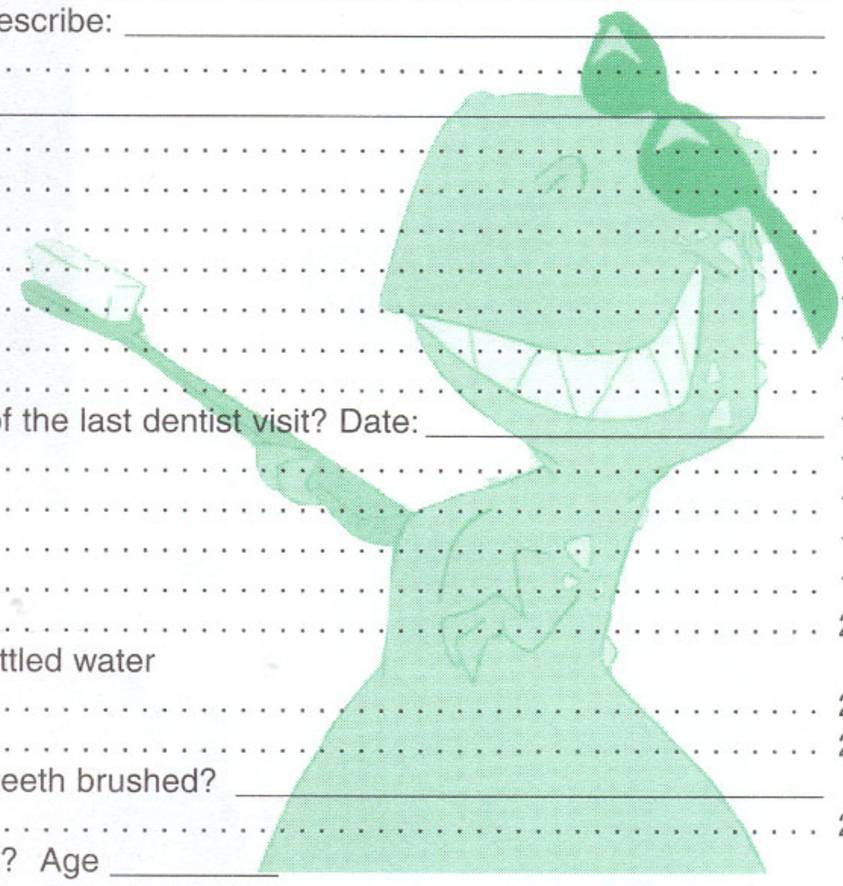
❑ Anemia	❑ Cancer	❑ Fainting	❑ Immunizations	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Growth Problems	❑ Kidney	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Hearing	❑ Latex allergy	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Heart	❑ Liver	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Hepatitis	❑ Mastoiditis	❑ Seizures	❑ Other _____
❑ Bones/Joints	❑ Epilepsy	❑ HIV +/AIDS	❑ Measles	❑ 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: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
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: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water		
22.	Does the child take fluoride supplements?	❑	❑
23.	Is fluoride toothpaste used?	❑	❑
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?	❑	❑
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: ❑ Mediical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____ Date _____

Form S707