

Child Health/Dental History Form

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth
Parent's/Guardian's Name		Relationship to Patient		Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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, or conditions related to, any of the following: <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Epilepsy <input type="checkbox"/> HIV +/-AIDS <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Fainting <input type="checkbox"/> Immunizations <input type="checkbox"/> Mumps <input type="checkbox"/> Other _____ <input type="checkbox"/> Asthma <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Growth Problems <input type="checkbox"/> Kidney <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Bladder <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Hearing <input type="checkbox"/> Latex allergy <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Bones/Joints <input type="checkbox"/> Ear Aches <input type="checkbox"/> Hepatitis <input type="checkbox"/> Measles <input type="checkbox"/> Thyroid				
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 prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain _____	2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, Please explain _____	3.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child ever had a serious illness? If yes, when _____ Please describe _____	4.	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the child ever been hospitalized?	5.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child have a history of any other illnesses? If yes, please list:	6.	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have any inherited problems?	7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever had a blood transfusion?	8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the child physically, mentally, or emotionally impaired?	9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child experience excessive bleeding when cut?	10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child currently being treated for any illnesses?	11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date _____	12.	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the child had any problem with dental treatment in the past?	13.	<input type="checkbox"/>	<input type="checkbox"/>
14. Has the child ever had dental radiographs (x-rays? exposed?	14.	<input type="checkbox"/>	<input type="checkbox"/>
15. Has the child ever suffered any injuries to the mouth, head or teeth?	15.	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problems with the eruption or shedding of teeth?	16.	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child had any orthodontic treatment?	17.	<input type="checkbox"/>	<input type="checkbox"/>
18. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water			
19. Does the child take fluoride supplements?	19.	<input type="checkbox"/>	<input type="checkbox"/>
20. Is fluoride toothpaste used?	20.	<input type="checkbox"/>	<input type="checkbox"/>
21. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____			
22. Does the child suck his/her thumb, fingers or pacifier?	22.	<input type="checkbox"/>	<input type="checkbox"/>
23. Does child participate in active recreational activities?	23.	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____

Date _____