Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth

Parent's/Guardian's Name	Relationship to Patient	Sex: M ☐ F ☐

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, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Tuberculosis
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Other_____
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Rheumatic fever	
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Seizures	
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Sickle Cell	
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ 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.	☐	☐
2.	Is the child allergic to any medications, I.e. penicillin, antibiotics, or other drugs? If yes, please explain _____	2.	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, Please explain _____	3.	☐	☐
4.	Has the child ever had a serious illness? If yes, when_____ Please describe _____	4.	☐	☐
5.	Has the child ever been hospitalized?	5.	☐	☐
6.	Has the child have a history of any other illnesses? If yes, please list:	6.	☐	☐
7.	Does the child have any inherited problems?	7.	☐	☐
8.	Has the child ever had a blood transfusion?	8.	☐	☐
9.	Is the child physically, mentally, or emotionally impaired?	9.	☐	☐
10.	Does the child experience excessive bleeding when cut?	10.	☐	☐
11,	Is the child currently being treated for any illnesses?	11.	☐	☐
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.	☐	☐
13.	Has the child had any problem with dental treatment in the past?	13.	☐	☐
14.	Has the child ever had dental radiographs (x-rays? exposed?	14.	☐	☐
15.	Has the child ever suffered any injuries to the mouth, head or teeth?	15.	☐	☐
16.	Has the child had any problems with the eruption or shedding of teeth?	16.	☐	☐
17.	Has the child had any orthodontic treatment?	17.	☐	☐
18.	**What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water			
19.	**Does the child take fluoride supplements?**	19.	☐	☐
20.	**Is fluoride toothpaste used?**	20.	☐	☐
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.	☐	☐
23.	Does child participate in active recreational activities?	23.	☐	☐

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 _____