Child Health / Dental History

Patient's Name:	Nickname:	Date of Birth:
Parent's/Guardian's Name:	Relationship to Patient:	
Address: PO Box or Mailing Address	City	State Zip Code
Phone: ( ) Home ( ) Work		Sex: M ☐ F ☐ Non binary ☐

Have you (the parent/guardian) or the patient had any of the following diseases or problems:
1. Active Tuberculosis **2.** Persistent cough greater than a three-week duration **3.** Cough that produces blood? ..... ☐ Yes ☐ No
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 condition related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Heart	☐ Latex allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Hepatitis	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/ Joints	☐ Ear Aches		☐ Measles	☐ Sickle cell	

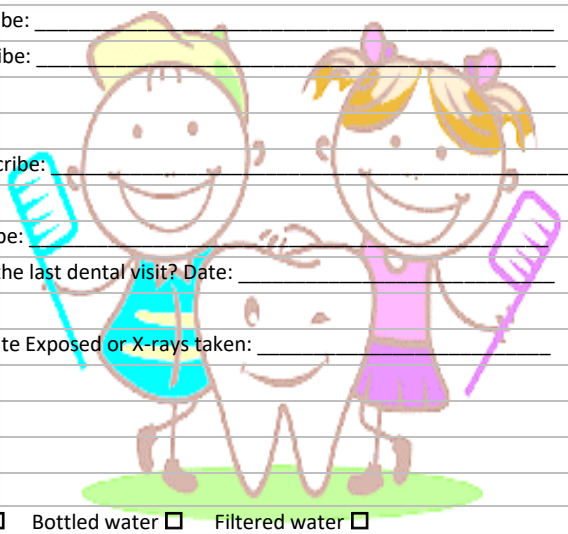
☐ Autism Spectrum Disorder (ASD) ☐ Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Please list the name and phone number of the child's physician: Physician Phone - -

Date of last physical exam:

Child's History

		Yes	No
1.	Is the child **currently** taking any prescription and/or over the counter medications or vitamin supplements ? 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.	Is the child **currently** pregnant? If yes, how many weeks?_____	☐	☐
5.	Has your child ever been pregnant or had a baby? YES ☐ NO ☐ If yes, normal vaginal delivery? YES ☐ NO ☐ **C-Section?** YES ☐ NO ☐		
6.	Was the child's baby placed in NICU or PICU after delivery?	☐	☐
7.	How would you describe the child's eating habits?		
8.	Has the child ever had a serious illness? If yes, when: _____Please describe: _____	☐	☐
9.	Has the child ever been hospitalized? If yes, when:_____ Please describe:_____	☐	☐
10.	Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
11.	Has the child ever received a general anesthetic If yes, please describe: _____	☐	☐
12.	Does the child have any inherited problems? If yes, please describe: _____	☐	☐
13.	Does the child have any speech difficulties?	☐	☐
14.	Has the child ever had a blood transfusion	☐	☐
15.	Is the child physically, mentally or emotionally impaired? If yes, please describe: _____	☐	☐
16.	Does the child experience excessive bleeding when cut?	☐	☐
17.	Is the child currently being treated for any illnesses? If yes, please describe: _____	☐	☐
18.	Is this the child's first visit to the dentist? If not, what was the date of the last dental visit? Date: _____	☐	☐
19.	Has the child had any problem with dental treatment in the past?	☐	☐
20.	Has the child ever had a dental radiographs (x-rays) exposed? If yes, Date Exposed or X-rays taken: _____	☐	☐
21.	Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
22.	Has the child had any problems with the eruption or shedding of teeth?	☐	☐
23.	Has the child had any orthodontic treatment?	☐	☐
24.	Does the child suck on his/her thumb, fingers or pacifier?	☐	☐
25.	What type of water does your child drink? City water ☐ Well water ☐ Bottled water ☐ Filtered water ☐		
26.	Is fluoride toothpaste used? YES ☐ NO ☐ Does the child take fluoride supplements? YES ☐ NO ☐		
27.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____		
28.	Do you floss your child's teeth? YES ☐ NO ☐ If yes, how often: _____		
29.	At what age did the child stop bottle feeding? Age: _____ Breastfeeding? Age: _____		
30.	What is the reason for your visit today?		
31.	How often does your child visit the dentist?_____ Name of former Dentist:		



Parent's/Guardian's Signature _____ Date _____

For Completion by dentist
Comments: _____
_____

Please mark (x) if any apply: ☐ Medical Alert noted ☐ Premedication Required ☐ Allergies **Reviewed by:** _____ **Date:**_____