

CHILD HEALTH HISTORY

In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.

Date: _____ Child's Name: _____
 Birthdate: _____ Age: _____ Gender: Male Female Nickname: _____
 Parent Name: _____ Parent Name: _____ Legal Guardian's Name: _____

Child's Physician: _____ Phone: _____
 Date of Last Physical Examination: _____ How is your child's general health? _____
 Has your child had any serious illness and/or hospitalization? Yes No
 If yes, describe and date: _____
 Is your child receiving any medication at this time? Yes No
 Medication name and reason: _____

Has your child ever had an allergic reaction or sensitivity reaction to the following:
 Dental Anesthetics Antibiotics Food Drugs Latex Nickel None
 Please name and describe reaction: _____
 Has your child ever received a blow or injury to his head or teeth? Yes No If yes, describe: _____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS?

1) ADD/ ADHD <input type="checkbox"/> Y <input type="checkbox"/> N	15) DIABETES TYPE I TYPE II <input type="checkbox"/> Y <input type="checkbox"/> N	29) PSYCHIATRIC PROBLEMS <input type="checkbox"/> Y <input type="checkbox"/> N
2) ADOPTED <input type="checkbox"/> Y <input type="checkbox"/> N	16) DOWN SYNDROME <input type="checkbox"/> Y <input type="checkbox"/> N	30) RADIATION THERAPY/CHEMO <input type="checkbox"/> Y <input type="checkbox"/> N
3) ANEMIA <input type="checkbox"/> Y <input type="checkbox"/> N	17) EMOTIONAL PROBLEMS <input type="checkbox"/> Y <input type="checkbox"/> N	31) RHEUMATIC FEVER <input type="checkbox"/> Y <input type="checkbox"/> N
4) ANXIETY <input type="checkbox"/> Y <input type="checkbox"/> N	18) EPILEPSY <input type="checkbox"/> Y <input type="checkbox"/> N	32) SEIZURES <input type="checkbox"/> Y <input type="checkbox"/> N
5) ASTHMA <input type="checkbox"/> Y <input type="checkbox"/> N	19) G-TUBE FEEDING <input type="checkbox"/> Y <input type="checkbox"/> N	33) SICKLE CELL ANEMIA <input type="checkbox"/> Y <input type="checkbox"/> N
6) AUTISM <input type="checkbox"/> Y <input type="checkbox"/> N	20) HEARING LOSS/IMPAIRMENT <input type="checkbox"/> Y <input type="checkbox"/> N	34) SKIN DISORDERS <input type="checkbox"/> Y <input type="checkbox"/> N
7) BLEEDING DISORDER <input type="checkbox"/> Y <input type="checkbox"/> N	21) HEART CONDITION <input type="checkbox"/> Y <input type="checkbox"/> N	35) SLEEP APNEA <input type="checkbox"/> Y <input type="checkbox"/> N
8) CANCER TYPE: <input type="checkbox"/> Y <input type="checkbox"/> N	22) HEART MURMUR <input type="checkbox"/> Y <input type="checkbox"/> N	36) SNORING <input type="checkbox"/> Y <input type="checkbox"/> N
9) CEREBRAL PALSY <input type="checkbox"/> Y <input type="checkbox"/> N	23) HEPATITIS A B C <input type="checkbox"/> Y <input type="checkbox"/> N	37) SYNDROME (SPECIFY) _____
10) CHRONIC EAR INFECTIONS <input type="checkbox"/> Y <input type="checkbox"/> N	24) HIV/AIDS <input type="checkbox"/> Y <input type="checkbox"/> N	_____
11) CLEFT LIP/ PALATE <input type="checkbox"/> Y <input type="checkbox"/> N	25) KIDNEY DISEASE <input type="checkbox"/> Y <input type="checkbox"/> N	_____
12) CYSTIC FIBROSIS <input type="checkbox"/> Y <input type="checkbox"/> N	26) LEARNING DISABILITIES <input type="checkbox"/> Y <input type="checkbox"/> N	38) Other _____
13) DELAYED SPEECH DEVELOPMENT <input type="checkbox"/> Y <input type="checkbox"/> N	27) LIVER DISEASE <input type="checkbox"/> Y <input type="checkbox"/> N	_____
14) DEVELOPMENTAL DELAY <input type="checkbox"/> Y <input type="checkbox"/> N	28) MUSCULAR DYSTROPHY <input type="checkbox"/> Y <input type="checkbox"/> N	_____

Comments: _____

Does your child have any habits we should know about, such as:
 Poor Eating Habits Finger/Thumb Sucking Pacifier Bottles Nail Biting Other: _____
 Family Dental History: Missing Teeth Extra Teeth Decay Underbite Overbite Jaw Surgery
 Other: _____

Does your child receive fluoride in: Drinking Water at Home Yes No By Prescription: Yes No
 Has your child had any unpleasant dental experiences? Yes No

How can we help?

Date of last dental examination: _____ Previous Dentist's Name: _____
 Has your child ever had orthodontic treatment? Yes No When? Where
 What is the nature of today's visit? Regular Exam Emergency State Problem: Other: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.