Child Health Questionnaire

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

Child's Physician: _____ Phone: _____

Date of Last Physical Examination: _____

How is your child's general health? _____

Has your child had any serious illness? ○ Y ○ N

If yes, describe: _____

Has your child ever been hospitalized? ○ Y ○ N

For what reason? _____

Is your child receiving any medication at this time? ○ Y ○ N

If yes, describe: _____

Has your child ever had an allergic reaction to the following?

☐ Dental Anesthetics ☐ Antibiotics ☐ Food ☐ Drugs ☐ Latex ☐ Nickel ☐ None

Please describe: _____

Has your child ever received a blow or injury to his/her head or teeth? ○ Y ○ N

Describe: _____

Has your child ever been treated with X-ray or radiation therapy? ○ Y ○ N

Has your child ever had any of the following conditions? *Please check:*

	Yes	No	Age		Yes	No	Age
Heart Disease	○ Y	○ N	_____	Lung Disease	○ Y	○ N	_____
Heart Surgery	○ Y	○ N	_____	Liver Disease	○ Y	○ N	_____
Previous Infective Endocarditis	○ Y	○ N	_____	Learning Disability	○ Y	○ N	_____
Diabetes	○ Y	○ N	_____	Emotional Disturbance	○ Y	○ N	_____
Scarlet Fever	○ Y	○ N	_____	Mental Disabilities	○ Y	○ N	_____
Kidney Disease	○ Y	○ N	_____	Mononucleosis	○ Y	○ N	_____
Epilepsy	○ Y	○ N	_____	Hearing Problems	○ Y	○ N	_____
Asthma	○ Y	○ N	_____	Sickle Cell Anemia	○ Y	○ N	_____
Hepatitis	○ Y	○ N	_____	**Check:** ☐ Disease ☐ Trait			
Aids or HIV	○ Y	○ N	_____	Other Condition (Please describe):			
Bleeding Problems	○ Y	○ N	_____				

How often does your child brush his/her teeth? _____

How often does your child floss? _____

Does your child have any habits we should know about, such as:

☐ Poor Eating Habits ☐ Thumb Sucking ☐ Pacifier ☐ Bottles Other _____

Does your child receive fluoride in: Drinking Water at Home ○ Y ○ N By Prescription ○ Y ○ N

Has your child had any unpleasant dental experiences? ○ Y ○ N

How can we help? _____

Date of last dental examination: _____ Previous Dentist's Name: _____

Has your child ever had orthodontic treatment? ○ Y ○ N When? _____

What is the nature of today's visit?

☐ Regular Exam ☐ Emergency State Problem: _____ ☐ Other _____

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered 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 child's health or medication.

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

PATIENT FORM