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? O Y O N

If yes, describe: _____

Has your child ever been hospitalized? O Y O N

For what reason? _____

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

Describe: _____

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

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

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

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 O Y O N By Prescription O Y O N

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

How can we help? _____

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

Has your child ever had orthodontic treatment? O Y O 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