CHILD HEALTH HISTORY

In order to provide a complete dental exam for your child, please answer the following questions as completely as possible. Data typed into this form can be saved.

Date: Child's Name: Child's Soc. Sec. No:

Birthdate: Age: Gender: ◯ Male ◯ Female Nickname:

Father's Name: Mother's Name:

Is Child Adopted? ◯ Yes ◯ No 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? ◯ Yes ◯ No

If yes, describe:

Has your child ever been hospitalized? ◯ Yes ◯ No

If yes, describe:

Is your child receiving any medication at this time? ◯ Yes ◯ No

For what reason?

Has your child ever had an allergic reaction or sensitivity 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 head or teeth? ◯ Yes ◯ No

If yes, describe:

Has your child ever been treated with X-ray or radiation therapy? ◯ Yes ◯ No

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Has your child ever had any of the following conditions? *Please check "Yes" or "No":*

	Yes	No	Age		Yes	No	Age		Yes	No	Age
Heart Disease/Surgery	◯	◯		Aids or HIV	◯	◯		TB (Tuberculosis)	◯	◯	
Heart murmur	◯	◯		Bleeding Problems	◯	◯		Sickle Cell Anemia	◯	◯	
Rheumatic Fever	◯	◯		Lung Disease	◯	◯		*Please select one:*			
Diabetes	◯	◯		Liver Disease	◯	◯		◯ Disease ◯ Trait			
Scarlet Fever	◯	◯		Learning Disability	◯	◯					
Kidney Disease	◯	◯		Emotional Disturbance	◯	◯		Other (Please Describe):			
Epilepsy	◯	◯		Mental Disabilities	◯	◯					
Asthma	◯	◯		Mononucleosis	◯	◯					
Hepatitis	◯	◯		Hearing Problems	◯	◯					

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 ◯ 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?

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.