# Child Health/Dental History Form

| Patient's Name (LAST / FIRST / INITIAL) | Nickname | Date of Birth |
|---|---|---|
| | | |
| **Parent's/Guardian's Name** | **Relationship to Patient** | **Sex: M ☐ F ☐** |
| | | |

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... ☐ Yes ☐ No

1. Active Tuberculosis 2. Persistent cough greater than a three-week duration 3. Cough that produces blood?

**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 conditions related to, any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Anemia | ☐ Cancer | ☐ Epilepsy | ☐ HIV +/AIDS | ☐ Mononucleosis | ☐ Tuberculosis |
| ☐ Arthritis | ☐ Cerebral Palsy | ☐ Fainting | ☐ Immunizations | ☐ Mumps | ☐ Other_____ |
| ☐ Asthma | ☐ Chicken Pox | ☐ Growth Problems | ☐ Kidney | ☐ Rheumatic fever | |
| ☐ Bladder | ☐ Chronic Sinusitis | ☐ Hearing | ☐ Latex allergy | ☐ Seizures | |
| ☐ Bleeding disorders | ☐ Diabetes | ☐ Heart | ☐ Liver | ☐ Sickle Cell | |
| ☐ Bones/Joints | ☐ Ear Aches | ☐ Hepatitis | ☐ Measles | ☐ Thyroid | |

**Please list the name and phone number of the child's physician:**

Name of Physician _____ Phone _____

# Child's History

| | | Yes | No |
|---|---|---|---|
| 1. | Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... 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. | Has the child ever had a serious illness? If yes, when_____ Please describe _____ | ☐ | ☐ |
| 5. | Has the child ever been hospitalized? ..... | ☐ | ☐ |
| 6. | Has the child have a history of any other illnesses? If yes, please list: ..... | ☐ | ☐ |
| 7. | Does the child have any inherited problems? ..... | ☐ | ☐ |
| 8. | Has the child ever had a blood transfusion? ..... | ☐ | ☐ |
| 9. | Is the child physically, mentally, or emotionally impaired? ..... | ☐ | ☐ |
| 10. | Does the child experience excessive bleeding when cut? ..... | ☐ | ☐ |
| 11, | Is the child currently being treated for any illnesses? ..... | ☐ | ☐ |
| 12. | Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date _____ | ☐ | ☐ |
| 13. | Has the child had any problem with dental treatment in the past? ..... | ☐ | ☐ |
| 14. | Has the child ever had dental radiographs (x-rays? exposed? ..... | ☐ | ☐ |
| 15. | Has the child ever suffered any injuries to the mouth, head or teeth? ..... | ☐ | ☐ |
| 16. | Has the child had any problems with the eruption or shedding of teeth? ..... | ☐ | ☐ |
| 17. | Has the child had any orthodontic treatment? ..... | ☐ | ☐ |
| 18. | **What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water | | |
| 19. | **Does the child take fluoride supplements?** ..... | ☐ | ☐ |
| 20. | **Is fluoride toothpaste used?** ..... | ☐ | ☐ |
| 21. | How many times are the child's teeth brushed per day?_____ When are the teeth brushed? _____ | | |
| 22. | Does the child suck his/her thumb. fingers or pacifier? ..... | ☐ | ☐ |
| 23. | Does child participate in active recreational activities? ..... | ☐ | ☐ |

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

**For completion by dentist**

Comments _____

_____

_____

_____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by _____

Date _____