HEALTH HISTORY

Date: _____ Update: _____

PERSONAL

Child's Full Name _____ Age _____ Birthdate _____

Nickname (if any) _____ Sex _____ Place of Birth _____

What is your child most interested in? _____

Brothers, names and ages? _____ Sisters _____

Is your child adopted? ❑ yes ❑ no If yes, does your child know? ❑ yes ❑ no

Child's pediatrician or physician _____ Telephone # _____

Family Dentist _____ Child attends what school? _____

MEDICAL

Has your child had any of the following medical problems? *Circle Yes (Y) or No (N).*

Allergies to drugs or foods	Y N	Ear infections	Y N	Hospital stays or operations	Y N
Allergies to Latex	Y N	Handicaps or disabilities	Y N	Learning disabilities	Y N
Asthma or lung problems	Y N	Heart defect (congenital)	Y N	Rheumatic Fever	Y N
Blood transfusions	Y N	Heart murmur	Y N	Trauma to mouth or face	Y N
Cancer	Y N	Hemophilia or abnormal bleeding	Y N	Tuberculosis (TB)	Y N
Convulsions or epilepsy	Y N	Hepatitis	Y N	Cerebral Palsy	Y N
Developmental delay	Y N	High fevers	Y N	Attention Deficit Disorder	Y N
Diabetes	Y N	HIV+ /AIDS	Y N		

Other medical problems: _____

Please discuss problems further, if necessary: _____

_____

_____

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y N

Is your child currently taking any medications? Y N What kind? _____

Is your child taking any supplemental fluoride? Y N If yes, how? Tablets, drops, water, vitamins (please circle)

Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? (please circle)

Does your child snore? Y N

HABITS

Does your child have any of the following habits?

Thumb or finger sucking	Y N	Pacifier use	Y N	Nail biting	Y N
Lip sucking or biting	Y N	Biting hard objects	Y N	Tooth grinding	Y N

Did your child use a bottle? Y N If yes, when did he/she stop? _____

Does your child currently use a bottle? Y N If yes, how often during the day? _____

Is the bottle used at night? Y N What do you put in the bottle? _____

Does your child currently nurse? Y N

FAMILY DENTAL HISTORY *(Circle appropriate parent, if yes)*

Has Mother or Father had a lot of decay? Has Mother or Father had orthodontic care?

Does Mother or Father have periodontal disease? Does Mother or Father have TMJ problems?

CHILD'S DENTAL HISTORY

Has your child seen a pediatric dentist before? Y N

If yes, the approximate month and year of last visit: _____ Where? _____

Has your child had any unfavorable experiences in a dental or medical office? Y N

Does your child have any dental problems presently? Y N

if yes, please explain: _____

How often does your child brush his/her teeth per day? _____ Do you help? Y N

How often does your child floss? _____ Do you floss your child's teeth? Y N

How do you think your child will act toward the dentist? _____

Purpose of today's dental visit? _____

Guardian's Initials _____ Date _____ Examining Doctor's Initials _____ Date _____