Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	DOB
Parent's/Guardian's Name	Relationship to Patient	
Address (P.O BOX OR MAILING ADDRESS / CITY / STATE / ZIPCODE)		
Home Phone: Work:	Patient's sex ☐ Female ☐ Male	

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, difficulty with, or diagnosis of any of the following:

☐ Anemia	☐ Cancer	☐ Fainting	☐ Immunizations	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Growth Problems	☐ Kidney	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Hearing	☐ Latex Allergy	☐ Pregnancy	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Heart	☐ Liver	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Hepatitis	☐ Mastoiditis	☐ Seizures	☐ Other _____
☐ Bones/Joints	☐ Epilepsy	☐ HIV+/AIDS	☐ Measles	☐ Sickle cell	

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

Name of Physician _____ Phone _____

CHILD'S MEDICAL HISTORY

		Yes	No
1.	Is the child taking any medications 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.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	☐	☐
6.	Has the child ever been hospitalized?	☐	☐
7.	Does the child have a history of any other illnesses?	☐	☐
8.	Has the child ever received a general anesthetic?	☐	☐
9.	Does the child have any inherited problems?	☐	☐
10.	Does the child have any speech difficulties?	☐	☐
11.	Has the child ever had a blood transfusion?	☐	☐
12.	Is the child physically, mentally or emotionally impaired?	☐	☐
13.	Is the child currently being treated for any illnesses?	☐	☐
14.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? _____	☐	☐
15.	Has the child had any problem with dental treatment in the past?	☐	☐
16.	Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
17.	Has the child ever suffered any problems with the eruption or shedding teeth?	☐	☐
18.	Has the child had any orthodontic treatment?	☐	☐
19.	What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water		
20.	Does the child take fluoride supplements?	☐	☐
21.	Is fluoride toothpaste used?	☐	☐
22.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____		
23.	Does the child suck his/her thumb, fingers or pacifier?	☐	☐
24.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		

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 m 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 from patient interview concerning health history _____
Significant findings from questionnaire or oral interview _____
Dental management considerations _____
Signature of Dentist _____