Child Health History Form

As required by law our, office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name _____ Date of Birth _____

Home ( ) _____ Cell Phone ( ) _____

May we use this number to send text notifications regarding your appointments? YES / NO

Parent/Guardian Name _____ Relationship to Patient _____

Address _____

City State Zip

Do you (parent/guardian) or the patient have any of the following diseases or problems?

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3-week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with Tuberculosis	☐	☐

If you answered yes to any of the 4 items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to the following (please circle):

Anemia	Arthritis	Asthma	Autism	Bladder	Bleeding disorders
Bones/Joints	Cancer	Cerebral palsy	Chicken pox	Chronic sinusitis	Diabetes
Ear aches	Epilepsy	Fainting	Growth problems	Hearing	Heart
Hepatitis	HIV+/AIDS	Immunizations	Kidney	Latex allergy	Liver
Measles	Mononucleosis	Mumps	Pregnancy (Teens)	Rheumatic fever	Seizures
Sickle cell	Thyroid	Tabacco/Drug use	Tuberculosis	Venereal disease	Other_____

Childs Physician _____ City_____Phone _____

Health History

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?
If yes, please list:

_____

Is the child allergic to any medications, i.e. penicillin, antiobiotics, or other drugs? If yes, please explain:_____

Is the child allergic to anything else, such as certain foods? If yes, please explain:_____

How would you describe the child's eating habits?_____

Has the child ever had a serious illness or hospitalization? If yes, when:_____ Please describe:_____

Has the child ever received general anesthetic?_____

Does the child have any inherited problems?_____

(Continued on other side)

⟹

Does the child have any speech difficultiies?_____

Has the child ever had a blood transfusion?_____

Is the child physically, metally, or emotionally impaired?_____

Does the child experience excessive bleeding when cut?_____

Is the child currently being treated for any illnesses?_____

Is this the child's first visit to a dentist?_____ If not the first visit, what was the date of the last dental visit?_____

Has the child had any problem with dental treatment in the past?_____

Has the child ever had dental radiographs (x-rays) exposed?_____

Has the child ever suffered any injuries to the mouth, head or teeth?_____

Has the child had any problems with the eruption or shedding of teeth?_____

Has the child had any orthodontic treatment?_____

Does the child take fluoride supplements?_____

Is fluoride toothpaste used?_____

How many times are the childs teeth brushed per day?_____

Does the child suck their thumb, fingers or pacifier?_____

At what age did the child stop breast feeding? Age _____ Bottle feeding?_____ Age_____

Does the child participate in active recreational activities?_____

NOTE: Both Doctor & patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read & understand the above and that the information given on this form is accurate, I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. 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 members of the 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.

Signature of Parent/Guardian: _____ **Date**: _____

FOR COMPLETION BY DENTIST

_____
_____
_____
_____
_____
_____
_____
_____