Child Health/Dental History Form

Patient's Name: Last First Middle Initial Nickname Date of Birth

Parent's/Guardian Name: Relationship to Patient:

Address: City State Zip Code

Phone- Home Work Cell Sex: M ☐ F ☐

Has the child had any history or, or conditions related to any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growing problems	☐ Kidney	☐ Diabetes
☐ Pregnancy (teens)	☐ Bladder	☐ Bleeding disorder	☐ Heart	☐ Liver
☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic fever	☐ Measles
☐ Venereal Disease	☐ Seizures	☐ Bones/Joints	☐ Hepatitis	☐ Tuberculosis
☐ Ear Aches	☐ Fainting	☐ HIV+/AIDS	☐ Other (list) _____	

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

Name of Physician: Phone:

Child History: Yes No

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? 1. ☐ ☐
   If yes, please list:_____
2. Is the child allergic to any medications, i.e. penicillin, antibiotic, or other drugs?_____ 2. ☐ ☐
   If yes, please explain_____
3. Is the child allergic to anything else, such as certain foods? If yes, explain_____ 3. ☐ ☐
4. Has the child ever had a serious illness?_____ 4. ☐ ☐
   If yes, when?_____ Please describe:_____
5. Has the child ever been hospitalized?_____ 5. ☐ ☐
6. Does the child have a history of any other illnesses? If yes, please list:_____ 6. ☐ ☐
7. Does the child have any inherited problems?_____ 7. ☐ ☐
8. Does the child have any speech difficulties?_____ 8. ☐ ☐
9. Has the child ever had a blood transfusion?_____ 9. ☐ ☐
10. Is the child physically, mentally, or emotionally impaired?_____ 10. ☐ ☐
11. Does the child experience excessive bleeding when cut?_____ 11. ☐ ☐
12. Is the child currently being treated for illness?_____ 12. ☐ ☐
13. Is this the child's first visit to the dentist?_____ 13. ☐ ☐
    If not the first visit, what was the date of the last visit?_____
14. Has the child had any problems with dental treatment in the past?_____ 14. ☐ ☐
15. Has the child suffered any injuries to the mouth, head or teeth?_____ 15. ☐ ☐
16. Has the child had any orthodontic treatment?_____ 16. ☐ ☐
17. What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled Water ☐ Filtered Water
18. Does the child take fluoride supplements?_____ 18. ☐ ☐
19. Is fluoride tooth paste used?_____ 19. ☐ ☐
20. How many times are the child's teeth brushed per day?_____ When are they brushed?_____
21. Does the child suck his/her thumb, fingers or pacifier?_____ 21. ☐ ☐
22. Does the child participate in active recreational activities?_____ 22. ☐ ☐

Note: Both doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my question, if any, about inquiries set forth 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_____