Child Health/Dental History Form

Patient Name | Date of Birth

Parent Name/Guardian | Relationship to patient

Address | Gender M□ F□

Phone

Has the child had any history of, or condition related to, any of the following: **Circle all that apply**

Anemia	Chronic Sinusitis	HIV/AIDS	Rheumatic Fever
Arthritis	Diabetes	Immunizations	Seizures
Asthma	Ear Aches	Kidney	Sickle Cell
Bladder	Epilepsy	Latex Allergy	Thyroid
Bleeding Disorder	Fainting	Liver	Tobacco/Drug Use
Bones/Joint issue	Growth Problems	Measles	Tuberculosis
Cancer	Hearing	Mononucleosis	Venereal Disease
Cerebral Palsy	Heart	Mumps	Other
Chicken Pox	Hepatitis	Pregnancy (teens)	

Please list the name and phone number of the child's physician:
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?	□	□
2. Is the child allergic to anything?	□	□
3. Has the child ever been hospitalized?	□	□
4. Does your child have any history of illness?	□	□
5. Has your child had any blood transfusions?	□	□
6. Does your child experience excessive bleeding when cut?	□	□
7. Is the child being treated for any illnesses?	□	□
8. Is this the child's first visit to a dentist? If not the first visit, when was the date of last visit? _____	□	□
9. Has the child had any problem with dental treatment in the past?	□	□
10. Has the child ever had any injuries to the mouth, head, or teeth?	□	□
11. Has the child ever had any problems with the eruption or shedding of teeth?	□	□
12. Has the child had orthodontic treatment?	□	□
13. What type of water does your child drink? □ City water □ Well water □ Bottled water □Filtered water		
14. Does your child take fluoride supplements?	□	□
15. Is fluoride toothpaste used?	□	□
16. How many times are the child's teeth brushed per day? _____ When are the teeth brushed_____	□	□
17. Does the child suck his/her thumb, fingers, or pacifier?	□	□
18. At what age did the child stop bottle feeding? Age_____ Breast feeding? Age_____	□	□
19. Does the child participate in recreational activities/sports?	□	□

Signature of parent/ guardian | Date