Child Patient Health History

Patient Name________________________________ Date of Birth__________ Today's Date__________

Child's Physician________________________________ Phone #________________________

Who May we thank for Referring you?____

Purpose of today's visit____

Date of last dental visit____________________ Previous Dentist________________________

Circle One

1. Does your child have any specific medical conditions- tuberculosis, cancer, cerebral palsy etc? 1. Yes No
   If so, please specify________________________________
2. Does your child have any specific limitations either mental or physical? 2. Yes No
   If so, please specify________________________________
3. Has your child ever had an operation? 3. Yes No
   If so, please specify________________________________
4. Have you ever been told by a physician that your child had/has a heart murmur, rheumatic fever, or a shunt? 4. Yes No
   At what age?___ Was a cardiogram ever done?_____ Is antibiotic coverage required for dental work?_____
5. Does your child have asthma or breathing problems? 5. Yes No
6. Does your child have a history of seizures? 6. Yes No
7. Has your child ever tested positive for Hepatitis or HIV? If so, please specify____________ 7. Yes No
8. Does your child have any allergies? Please specify: 8. Yes No

Antibiotics	Yes	No
Analgesics (aspirin, codeine)	Yes	No
Latex	Yes	No
Pollen, grass, dust, animals	Yes	No

9. Is your child now taking any medications? If so please list____________________ 9. Yes No
10. Does your child have any learning difficulties, ADD, or ADHD? If so, please specify__________ 10. Yes No
11. Has your child ever had a transfusion of whole blood or any blood products? Which?________ 11. Yes No
12. Does your child have any social difficulties? 12. Yes No
13. Is your child adopted? 13. Yes No
14. Is your child in foster care? 14. Yes No
15. Are parents separated, divorced, widowed, never married? (Question asked in order that the emotional status of child may be better understood)
16. Has your child had a history of thumb sucking, finger sucking, lip sucking, pacifier use, or nail biting? 16. Yes No
17. Was your child's pregnancy or delivery abnormal in any way? 17. Yes No
18. Was your child breast fed?______ Bottle fed?_______ any difficulties?___________
19. Has your child ever had a prolonged fever for any reason? 19. Yes No
20. Has your child ever had any unfavorable experience in a medical or dental office? 20. Yes No
21. Has your child ever had any injuries to the teeth, mouth, head, or neck?
    If so, please specify________________________________ 21. Yes No
22. Has the child's natural parents ever had a lot of decay or crooked teeth? 22. Yes No
23. Is the child's mother or father afraid of dental care? 23. Yes No
24. Has your child had a toothache lately? 24. Yes No
    If yes, was the pain after eating?______ Did it awaken the child from sleep?_______
25. How do you think your child will react to this dental visit?
    Very poor?_____ Poor?______ Well?______ Very Well?_______
26. Are there any other questions, conditions, or concerns not listed here? 16. Yes No
    If so, please specify________________________________
    To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

______________________________ ____________________

Signature of parent or guardian date