HEALTH HISTORY

CHILD'S NAME: ____AGE_____________________ SEX: ❑M ❑F
CHILD'S PHYSCIAN ___________________________________ PHONE: ____________________________________
DATE OF LAST PHYSICAL EXAM __________________________VACCINATIONS UP TO DATE? ❑Y ❑N

COMMENTS

1. Is your child under a physician's care now? ❑N ❑Y____
2. Is your child receiving any medications or drugs? ❑N ❑Y ____
3. Has your child ever been hospitalized? ❑ N ❑Y ____
   Has your child ever had surgery? ❑N ❑ Y Dates:____
   Please Explain ____
4. Is your child allergic to any: a) Medications? ❑N ❑Y ____
   b) Latex, Foods, metals, etc? ❑N ❑Y ____
5. Were there any difficulties during the pregnancy or delivery of your child? ❑N ❑Y _________________________
6. Are there any emotional problems? ❑N ❑ Y____

Please explain any "Yes" answers.____
____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS OR PROBLEMS YOUR CHILD MAY HAVE NOW OR MAY HAVE HAD IN THE PAST. (*INDICATE A PAST CONDITION BY CIRCLING.*)

Y N		Y N		Y N		Y N	
❑❑	ADD or ADHD	❑❑	Chicken Pox	❑❑	Kidney	❑❑	Seizures or convulsions
❑❑	AIDS or HIV positive	❑❑	Diabetes	❑❑	Liver	❑❑	Sinus infections
❑❑	Anemia	❑❑	Epilepsy	❑❑	Malignancies	❑❑	Speech
❑❑	Asthma	❑❑	Fainting	❑❑	Mononucleosis	❑❑	Tonsillitis
❑❑	Bladder infections	❑❑	Hepatitis	❑❑	Mumps	❑❑	Thyroid
❑❑	Bleeding problems	❑❑	Hearing	❑❑	Nutritional Problems	❑❑	Tuberculosis
❑❑	Cerebral Palsy	❑❑	Heart (Describe)	❑❑	Recurrent Earaches	❑❑	Vision
❑❑	Congenital birth problems	❑❑	Genetic Conditions	❑❑	Rheumatic Fever		

*PLEASE EXPLAIN*____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURY, OR ANY OTHER INFORMATION I SHOULD BE AWARE OF.

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❑ MY CHILD HAS NO KNOWN MEDICAL CONDITIONS!

DENTAL HISTORY Name of previous dentist: ______________________________________

Reason for this appointment. ____
How do you feel about the condition of your child's mouth or teeth? ____
Date of last dental visit _________________ For what service? ____
Were X-rays taken? ❑ N ❑Y Was all recommended treatment completed? ❑ N ❑Y
Has your child had any unpleasant dental experiences? ❑ N ❑Y
If **"Yes",** please explain. ____
Has your child complained about any dental problems? ❑N ❑Y ____
Has your child ever had any injuries to the mouth, teeth, or head? ❑N ❑Y __________________________________
Please circle any oral habits your child may have: ● Thumb sucking ●Pacifier ●Nail-biting ● Mouthbreathing
Has your child ever worn orthodontic appliances? ❑N ❑Y Orthodontist Name:________________________________
Is your child a frequent snacker? ❑N ❑Y Please describe ____
Does your child have a history of going to bed or carrying around a baby bottle filled with juice or milk? ❑N ❑Y
Does your child brush his/her teeth daily? ❑N ❑Y ****** Floss? ❑N ❑Y How often? ___________________
Does an adult assist your child with brushing? ❑N ❑Y ******* With flossing? ❑N ❑Y
My child receives regular fluoride (circle for "Yes"): ●Drops ●Tablets ●Water ●Toothpaste ●Prefer no fluoride
Are there any family dental problems you are concerned may be present in your child? ❑N ❑Y ________________________
____
Doctor's summary:____
____Reviewed by: ______________