Child Health/Dental History Form

Child's Full Name	Nickname	Date of Birth
Parent/Guardian Name	Relationship to Patient	
Address		
Phone #	Email Address	

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

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

Please describe any responses checked above or any other past/current illnesses including any hospitalizations:

Name of Child's Physician Clinic Name Phone #

Does the child have <u>ALLERGIES</u> to any medications or anything else, such as certain foods? Please list:

Does the child currently take any prescription or over-the-counter medications, supplements or vitamins? Please list:

1. Has the child ever received general anesthetic?.....Y N
2. Is the child physically, mentally, or emotionally impaired?..... Y N
3. Does your child have any learning or communication challenges? .....Y N
4. Does the child have any speech difficulties?.....Y N
5. Does your child snore?..... Y N
6. Has the child had any problem with dental treatment in the past? ..... Y N
7. Has the child ever had dental radiographs (x-rays) exposed? ..... Y N
8. Has the child ever suffered any injuries to the mouth, head or teeth? ..... Y N
9. Has the child had any problems with the eruption or shedding of teeth? ..... Y N
10. Has the child had any orthodontic treatment? ..... Y N
11. What type of water does your child drink? Please circle: City Well Filtered Bottled
12. Is fluoride toothpaste used? ..... Y N
13. Does the child suck on a pacifier, thumb, finger or blanket? ..... Y N
14. At what age did the child stop bottle feeding? _____ Breast feeding? _____
15. Does the child participate in activities where an athletic mouthguard is needed? ..... Y N

Interests: _____

Siblings: _____ Pets: _____

Parent Signature: _____ Date: _____

Doctor Signature: _____ Date: _____