Health History

Patient____Date___________________

Yes No Is your child in good health?

Yes No Are your child's vaccinations up to date?

Yes No Has your child ever had a health problem?__________________________

Yes No Has your child ever been hospitalized? Please give reason and dates_______

____

Yes No Is your child allergic to any medicines/food/substances? _______________

____

Yes No Is your child currently taking any medications? Please give medication and reason____

Yes No Has your child received general anesthesia/sedation?

Yes No Has your child ever received a blood transfusion?

Yes No Were there any problems at birth?______________________________

Please check if your child has been treated for any of the following:

Heart disease/murmur	Eye problems	Kidney disease	ADD/ADHD
Bleeding/transfusions	Speech/hearing	Diabetes	Autism Spectrum Disorder
Sickle cell anemia	Ear infections	Thyroid Problems	Brain injury
Anemia	Asthma	Cerebral palsy	Mental delays
Hepatitis	Mouth breathing	Seizures	Physical delays
HIV/AIDS	Snoring	Spina Bifida	Social delays
Rheumatic fever	Cleft lip/palate	Liver/GI disease	Congenital birth defects
Leukemia/cancer	Tuberculosis	Orthopedic problems	Other problems

Please elaborate on any items checked:____

____

____

Name of Pediatrician _______________________________Last physical exam___________

Name of Pediatric Specialists (if applicable) _______________________________________

Yes No If necessary, may we consult with these physicians?

Dental History

Patient____Date___________________

Yes No Has your child ever been to the dentist? Name of dentist and date________
____

Yes No Has your child experienced any unfavorable reaction from previous dental care?
Explain____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Do you assist your child with toothbrushing? How many times/day ________

Yes No Do you assist your child with flossing? How many times/week ____________

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Does your child's jaw make noise and is pain associated with the sounds?

Was your child 8 breast fed 8 bottle fed At what age was it stopped?_______________

Please check if your child is having problems with any of the following:

Cavities	Toothache	Teeth Sensitive
Trauma	Gum Infections	Color of teeth
Orthodontics	Jaw Sounds	Other

Comments: ____

Fluoride History

Yes No Does your child use a fluoride toothpaste?

Yes No Do you give your child any other form of fluoride? What?_______________

Signature____ Date ___________________

Dentist Signature ____________________________________ Date ___________________