

# CHILD'S HEALTH HISTORY

## DENTAL HISTORY

CHILD'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF LAST VISIT TO A DENTIST \_\_\_\_\_ SERVICES? \_\_\_\_\_

YES NO HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS? \_\_\_\_\_

YES NO ANY UNHAPPY DENTAL EXPERIENCES? \_\_\_\_\_

YES NO ANY INJURIES TO MOUTH/TEETH/HEAD? \_\_\_\_\_

YES NO ANY MOUTH HABITS (THUMBSUCKING, PACIFIER, ETC.)? \_\_\_\_\_

YES NO ANY UNUSUAL SPEECH HABITS? \_\_\_\_\_

YES NO ANY LOST TEETH? \_\_\_\_\_

YES NO HAVE MISSING TEETH BEEN REPLACED? \_\_\_\_\_

YES NO ORTHODONTIC APPLIANCES WORN NOW OR EVER BEEN? \_\_\_\_\_

YES NO DOES YOUR CHILD BRUSH TEETH DAILY? \_\_\_\_\_

YES NO DO YOU ASSIST CHILD WITH TOOTH BRUSHING? \_\_\_\_\_

YES NO HOW OFTEN? \_\_\_\_\_

YES NO IS DENTAL FLOSS USED? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

YES NO ARE DISCLOSING TABLETS USED? \_\_\_\_\_

YES NO IS FLUORIDE TAKEN IN ANY FORM? \_\_\_\_\_

YES NO DO YOU DESIRE COMPLETE DENTAL SERVICE FOR THE CHILD? \_\_\_\_\_

CHILD'S ATTITUDE TO DENTISTRY? \_\_\_\_\_

## DOCTOR'S NOTES:

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PLEASE COMPLETE OTHER SIDE

# CHILD'S MEDICAL HISTORY

CHILD'S PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

RESULTS \_\_\_\_\_

YES NO IS CHILD UNDER CARE OF PHYSICIAN NOW? \_\_\_\_\_

YES NO IS CHILD RECEIVING ANY MEDICATION OR DRUGS? \_\_\_\_\_

YES NO HAS CHILD EVER BEEN HOSPITALIZED? \_\_\_\_\_ WHEN? \_\_\_\_\_

YES NO HAS CHILD EVER HAD SURGERY? \_\_\_\_\_

YES NO DOES CHILD HAVE GOOD PHYSICAL COORDINATION? \_\_\_\_\_

YES NO ARE THERE ANY EMOTIONAL PROBLEMS? \_\_\_\_\_

YES NO ARE THERE OTHER ALLERGIES: FOOD, POLLEN, ANIMALS, DUST, OTHER? \_\_\_\_\_

## HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?:

Y N ANEMIA	Y N BLADDER	Y N EPILEPSY	Y N LIVER	Y N RHEUMATIC FEVER
Y N ACQUIRED IMMUNE DEFICIENCY SYNDROME	Y N CEREBRAL PALSY	Y N FAINTING	Y N MALIGNANCIES	Y N THYROID
Y N ASTHMA	Y N CHICKEN POX	Y N HEARING	Y N MASTOID	Y N TUBERCULOSIS
Y N AIDS RELATED COMPLEX	Y N CHRONIC SINUS	Y N HEART	Y N MEASLES	Y N VENEREAL DISEASE
Y N CONVULSIONS	Y N HIV	Y N MONONUCLEOSIS	Y N OTHER	
Y N DIABETES	Y N KIDNEY	Y N MUMPS		

SUMMARY: (FOR DOCTOR'S USE) \_\_\_\_\_

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES, OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

MAY WE REQUEST RELEASE OF YOUR CHILD'S MEDICAL RECORDS FOR OUR REFERENCE? \_\_\_\_\_

THIS INFORMATION WAS DISCUSSED WITH AND GIVEN BY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_