# 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 ANY ALLERGIES TO MEDICATIONS? ______________________________________

**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 | Y N CEREBRAL PALSY | Y N FAINTING | Y N MALIGNANCIES | Y N THYROID |
| DEFICIENCY SYNDROME | Y N CHICKEN POX | Y N HEARING | Y N MASTOID | Y N TUBERCULOSIS |
| Y N ASTHMA | Y N CHRONIC SINUS | Y N HEART | Y N MEASLES | Y N VENEREAL DISEASE |
| Y N AIDS RELATED | Y N CONVULSIONS | Y N HIV | Y N MONONUCLEOSIS | Y N OTHER |
| COMPLEX | Y N DIABETES | Y N KIDNEY | Y N MUMPS | |

## SUMMARY: (FOR DOCTOR’S USE)______________________________________________
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________________________________________________________________________________

**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.**
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**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**______________________