HEALTH HISTORY

CHILD'S NAME:_____ **DOB:**_____

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important affect in the dental treatment your child receives.
Thank you for thoroughly answering the following questions.

MEDICAL

1 Date of last physical exam? _____ **Weight:**_____
2 Is your child under medical care? ..... **YES NO**
If so, for what?_____
3 Has your child been hospitalized? ..... **YES NO**
If so, for what reason?_____
4 Has your child ever had any serious illness or operation? **YES NO**
If so, please explain?_____
5 Does your child have seasonal allergies? ..... **YES NO**
6 Is your child on a Gluten free diet? ..... **YES NO**
7 Was your child born premature? ..... **YES NO**
If yes, how many weeks?_____
8 Does your child bruise easily? ..... **YES NO**
9 Does he/she have any blood disorders? ..... **YES NO**
10 Has he/she ever required a blood transfusion? ..... **YES NO**
11 Has your child had abnormal bleeding associated with any previous surgery, extraction or cuts? ..... **YES NO**
If so, for what?_____
12 Does your child urinate more than six times a day? ..... **YES NO**
13 Is your child thirsty much of the time? ..... **YES NO**
14 Is your child wheelchair bound? ..... **YES NO**
15 Does your child snore? ..... **YES NO**
16 Is your child undergoing any type of therapy? ..... **YES NO**
□ Speech □ Physical □ Occupational
□ Other: _____
17 Does your child have any known allergies or has child ever reacted adversely to any of the following: **YES NO**
□ Codeine □ Latex □ Local Anesthetics □ Penicillin or other antibiotics
□ Sulfa Drugs □ Sedatives □ Tree Nuts □ Food
Please specify type(s) of food:_____
Any other?_____
What adverse reaction occurred?_____
18 Is your child taking any of the following medications? ..... **YES NO**
□ Antibiotics or Sulfa Drugs □ Asthma Medications □ Aspirin
□ Anticoagulants (blood thinners) □ Blood Pressure □ Tranquilizers
□ Cortisone or Steroids □ Dilantin or other Anticonvulsant
□ Insulin, Tolbutamide, Orinase, or similar drug □ Iron Supplements
□ Other? _____
List all medications your child is taking including herbal medicines and vitamins.
(Please specify frequency and dosage below)
_____

Has your child had or does your child currently have any of the following?...

19 ADD/ADHD Date of Diagnosis:_____ **YES NO**
20 AIDS/HIV Date of Diagnosis:_____ **YES NO**
21 Anemia Date of Diagnosis:_____ **YES NO**
22 Arthritis/Inflammatory Rheumatism ..... **YES NO**
23 Asthma Date of Diagnosis:_____ **YES NO**
If yes, please complete the following...
Has your child ever been hospitalized due to Asthma? ..... **YES NO**
Does your child use an Inhaler? ..... **YES NO**
Does he/she have a Nebulizer at home? ..... **YES NO**
What triggers your child's asthmatic episodes?
□ Illness □ Environment/Change of Season □ Exercise □ Stress/Anxiety
How frequent are they?_____
Date of last episode?_____
24 Autism Date of Diagnosis:_____ **YES NO**
25 Cancer/Leukemia Date of Diagnosis:_____ **YES NO**
If yes, please complete the following...
□ Currently □ In Remission
Does your child currently have his/her blood counts checked on a regular basis? ..... **YES NO**
Has your child undergone Chemotherapy? ..... **YES NO**
26 Cardiovascular Disease/Heart Trouble..... **YES NO**
(congenital heart disease, heart murmur, ASD, VSD, Stroke, Rheumatic Fever)
If yes, please complete the following...
Per your child's physician have you been advised that antibiotics are required prior to dental procedures? **YES NO**
If heart murmur, please indicate: □ Innocent □ Organic
27 Cerebral Palsy Date of Diagnosis:_____ **YES NO**
28 Cleft □ Lip □ Palate □ Both **YES NO**
29 Cystic Fibrosis..... **YES NO**
30 Developmentally Delayed..... **YES NO**
31 Diabetes Type: _____ Date of Diagnosis:_____ **YES NO**
32 Down Syndrome..... **YES NO**
33 Eczema..... **YES NO**
34 Epilepsy..... **YES NO**
35 Fainting Spells/Dizziness..... **YES NO**
36 Hearing Disability .....□ Wears a Hearing Aide **YES NO**
□ Left Ear □ Right Ear □ Both Ears
37 Hemophilia..... **YES NO**
38 Hepatitis If so, what type? □ A □ B □ C **YES NO**
39 High Blood Pressure..... **YES NO**
40 Hives or Skin Rash..... **YES NO**
41 Hypoglycemia..... **YES NO**
42 Irregular Heartbeat..... **YES NO**
43 Jaundice.....□ At Birth Only **YES NO**
44 Kidney Trouble..... **YES NO**
45 Liver Disease..... **YES NO**
46 Low Blood Pressure..... **YES NO**
47 Persistent cough or cough up blood..... **YES NO**
48 Psychiatric Care..... **YES NO**
49 Reflux..... **YES NO**
50 Seizures Date of Last Seizure:_____ **YES NO**
□ Febrile □ Petit mal □ Grand mal
51 Sickle Cell Disease Date of Diagnosis: _____ **YES NO**
52 Sleep Apnea..... **YES NO**
53 Spina Bifida..... **YES NO**
54 Stomach/Intestinal Disease..... **YES NO**
55 Thyroid Disease..... **YES NO**
56 Tuberculosis (TB Positive skin test)..... **YES NO**
Result of the chest x-ray? □ Negative □ Positive
57 Tumors or Growths..... **YES NO**
58 Ulcers..... **YES NO**
59 Venereal Disease Type: _____ **YES NO**
60 Visually Impaired Wears: □ Contacts □ Glasses **YES NO**
□ Left □ Right □ Both eyes

Please note any other medical conditions not listed above:

DENTAL

61 Is today's visit your child's 1st dental visit? ..... **YES NO**
If not, what is the date of his/her last dental examination?_____
62 Does your child have a disability that prevents treatment in a dental office setting? ..... **YES NO**
63 Has he/she had any serious trouble associated with previous dental treatment? ..... **YES NO**
If so, please explain?_____
64 Do your child's gums bleed when brushing? ..... **YES NO**
65 Has he/she ever been treated for any type of gum disease? ..... **YES NO**
66 Has he/she had any injuries to his/her mouth or jaws? ..... **YES NO**
67 Does your child grind or clench his/her teeth? ..... **YES NO**
68 Has he/she had toothaches or sores in his/her mouth? ..... **YES NO**
69 Does or has he/she had orthodontic treatment (braces)? ..... **YES NO**
If applicable, Name of Orthodontist:_____
70 Have you been satisfied with your child's previous dental care? ..... **YES NO**
If not, please explain:_____

DISCLOSURE AND CONSENT OF PARENTS

To the best of my knowledge, all of the proceeding answers are true and correct.
I understand, if there is any change in my child's health history and/or the medications he/she takes, I will inform the doctor at the next appointment without fail.

_____ _____ _____
PARENT'S/LEGAL GUARDIAN'S SIGNATURE **DATE** **REVIEWED BY**