

# Health History

Your child's overall health, as well as any medications which your child takes, could impact the dental care your child receives. Please answer each of the following questions completely.



Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

## Health Information

Has your Child ever had any of the following diseases or medical problems?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Kidney problems                    | <input type="checkbox"/> Latex allergy  |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Joint replacement                  | <input type="checkbox"/> HIV/AIDS       |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Excessive bleeding<br>(Hemophilia) | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Epilepsy/seizures                  | <input type="checkbox"/> Lung problems  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Psychological disorders            | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Liver problems          | <input type="checkbox"/> Nervous system disorders           | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Hives/Rashes                       | <input type="checkbox"/> ADHD           |
| <input type="checkbox"/> Other _____             |   |   |

Is your child taking any medications? Yes  No

If yes, please list? \_\_\_\_\_

Does your child need antibiotic pre-medication prior to the dental appointment? Yes

No

Is your child allergic to any medications or anesthetic? Yes  No

If yes, please list? \_\_\_\_\_

Is your child in good health? Yes  No

Name of child's physician? \_\_\_\_\_

Phone number of child's physician: \_\_\_\_\_

Is there any condition or problem related to your child's medical history that has not been mentioned? \_\_\_\_\_

## Dental Habits

Is your child's water fluoridated? Yes  No

Does your child take fluoride supplements? Yes  No

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

When was your child's last Dental visit? \_\_\_\_\_

Does your child have a thumb/finger sucking habit? \_\_\_\_\_

## Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my

child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers or health practitioners.

Signature of parent or guardian\_\_\_\_\_

Print name of parent or guardian\_\_\_\_\_

Date\_\_\_\_\_

Reviewed by:\_\_\_\_\_

Date:\_\_\_\_\_

\_\_\_\_\_