CHILD HEALTH HISTORY

Patient's Name:________________________________ Birth Date: __________Today's Date_________

Parent's/Guardian's Name & ☎ Number____

Please answer the following questions. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This clinic does not use this information to discriminate.

Allergies: Circle all that apply	**None**	
Amoxicillin	Erythromycin	Sulfa
Aspirin	Latex	Tetracycline
Anesthetics	Metals/Jewelry	Other____________________
Codeine	Penicillin	

Does your child need a **premedication (antibiotic)** prior to dental work for reasons such as; **artificial joints, pins, screws, places heart valves or shunts**? **YES/NO** If yes, Date __/__/__

Is your child taking a blood thinner medication such as **Coumadin** , **Warfarin or Plavix** ? **YES/NO**

Is this your child's first dental appointment? **YES/NO** If no, date of last appointment __/__/__

Does your child have any of the following conditions? **Please check ☑ YES or ☑ NO**

	YES	NO		YES	NO
Anemia	☐	☐	HIV/AIDS	☐	☐
Asthma	☐	☐	Jaundice (not at birth)	☐	☐
Anorexia/Bulimia	☐	☐	Kidney Disease	☐	☐
Autism	☐	☐	Learning Disabilities	☐	☐
Birth Defects	☐	☐	Liver Disease	☐	☐
Bleeding Problems	☐	☐	Mental Illness	☐	☐
Blood Disorder	☐	☐	Muscular Dystrophy	☐	☐
Cancer	☐	☐	Pregnant (at this time)	☐	☐
Cerebral Palsy	☐	☐	Rheumatic Fever	☐	☐
Delayed Speech Development	☐	☐	Sickle Cell Anemia	☐	☐
Developmental Delay	☐	☐	Sinus Problems	☐	☐
Diabetes	☐	☐	Smoking/Tobacco	☐	☐
Down Syndrome	☐	☐	Tuberculosis	☐	☐
Emotional/Psychiatric Problems	☐	☐	Tumor/Growth	☐	☐
Epilepsy/Seizures	☐	☐	Venereal Disease	☐	☐
Fainting Spells	☐	☐	Radiation Treatment	☐	☐
Hearing Loss/Impairment	☐	☐	Other ________________________	☐	☐
Heart Condition/Murmur	☐	☐	______________________________		
Hepatitis A B C D	☐	☐	______________________________		
Herpes/Cold Sores	☐	☐	______________________________		

OVER➔

Primary Physician's Name____ ☎ Number_________________

Has your child had any serious illnesses or surgeries? **YES/NO** If yes, describe___________________________________

Has your child ever had a blood transfusion? **YES/NO** If yes, give date____

Current List of Medications	Reason Taking	How Much	How Often

Please Note: Both doctor and parent/ legal guardian are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my child's dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent/Legal Guardian's

Signature____Date_______________

With a return visit, a parent/ legal guardian's signature is required to indicate the health history has been reviewed and any changes have been made after the original date on the health history.

_________________________/________

Signature of Parent / Legal Guardian /Date

_________________________/________

Signature of Parent / Legal Guardian/Date

_________________________/________

Signature of Parent / Legal Guardian /Date

_________________________/________

Signature of Parent / Legal Guardian/Date

FOR OFFICE USE ONLY

_________________________/________

Signature of Dentist / Hygienist/Student

_________________________/________

Signature of Dentist / Hygienist/Student

_________________________/________

Signature of Dentist / Hygienist/Student

_________________________/________

Signature of Dentist / Hygienist/Student