HEALTH HISTORY

Date:_____ Child's Name:_____ Date of Birth:_____

Address:_____ Height _____ Weight_____
Street City State Zip

Parent/Guardian Name:_____ Email:_____

Primary Phone: ( )_____ h/c/w Secondary Phone: ( )_____ h/c/w

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Please answer the following questions by circling Y=Yes or N=No

Y N Is this your child's first dental visit? If no, how long since last dental examination? _____
Y N Is this an emergency visit? If yes, please explain _____
Y N Has your child had any unfavorable dental experiences?
Y N Have any teeth been removed by a dentist?
Y N Does your child have a problem with his/her bite or position of teeth?
Y N Has your child been seen by an orthodontist?
Y N Has your child worn orthodontic appliances?
Y N Does your child use dental floss?
Y N Is fluoride taken in any form? (Water, tablets, etc.)
Y N Does your child have a history of: (Circle one) Finger or Thumb sucking Lip sucking Nail Biting Use of Pacifier
Y N Have there been any injuries to the teeth? If yes, please explain:_____
Y N Is your child currently under the care of a Physician? If yes for what reason?_____
Y N Is you child currently taking any medications?
Medicine:_____ Dosage:_____
Y N Is your child sensitive or allergic to any drugs?
If yes, please list: _____
Y N Does your child have a history of allergies?
Y N Is your child allergic to Latex?
Y N Has you child had a history of any of the following (please circle)

Heart trouble	Rheumatic Fever	Seizure disorder	Cerebral Palsy or spastic condition
Tuberculosis	Kidney/Liver Disease	Profuse Bleeding	Hearing Impairment
Asthma	Mental Disturbance	Speech Impairment	Any Communicable Diseases

Y N Has your child had any childhood diseases other than chicken pox, measles or mumps?
Y N Has your child ever been hospitalized or had surgery?
If yes, explain: _____
Y N Does your child have a handicap, learning disability, or other special problems?
If yes, explain: _____
How many times a day does your child brush his/her teeth? _____

Name of your child's Physician: _____ Phone #:_____

Would you like an orthodontic evaluation for your child? Yes / No
Would you like a referral to a dentist for yourself? Yes / No

Parent/Guardian Signature:_____ Date:_____

OFFICE USE ONLY:

Date:_____ Initials:_____ Comments:_____
Date:_____ Initials:_____ Comments:_____
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Date:_____ Initials:_____ Comments:_____