

Children's Dentistry

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Health History

Patient's Name _____
(first) (Last)

Birthdate _____ Boy Girl (please circle)

Patient's Physician _____ Phone _____

Address _____

Specialist _____ Phone _____

Is/Has Child:

Yes No
✓ ✓ if yes:

Any illness now? Type _____

Receiving any medications or drugs? List _____

Ever been hospitalized? Date _____

Ever had surgery? Date _____

Allergic to any medications? List _____

Allergic to latex products? List _____

Are there any other allergies? List _____

Has/Had any history of:

(please circle)

Anemia	Y N	Hearing Problem	Y N	Rheumatic Fever	Y N
Asthma	Y N	Heart Problem	Y N	Sleep Apnea	Y N
Autism	Y N	Heart Murmur	Y N	Tuberculosis	Y N
Bleeding Disorder	Y N	Hepatitis	Y N	Tumors/Cancer	Y N
Diabetes	Y N	HIV/AIDS	Y N	Special Needs/Other:	_____
Emotional Problem	Y N	Kidney Disease	Y N	_____	_____
Epilepsy/Convulsions	Y N	Liver Disease	Y N	_____	_____
Fainting or Dizziness	Y N	Mental Disorder	Y N	_____	_____

Dental History

Reason for this appointment _____

How do you feel about the condition of your child's mouth and teeth? _____

Date of last dental visit _____

For what service? _____

Name of former dentist _____

Has Child:

Yes No
✓ ✓ if yes:

Complained about dental problems? _____

Had any unhappy dental experiences? _____

Had any injuries to mouth, teeth or head? _____

Had any mouth habits such as thumbsucking
nail-biting, mouth breathing, pacifier, etc.? _____

Had adverse reactions to anesthetics? _____

Is fluoride taken in any form? _____

Child's attitude toward dentistry _____

Parent or Guardian Signature _____ Date _____

Reviewed By Dr. Jackson on _____