

# Children's Dentistry

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## Health History

Patient's Name \_\_\_\_\_  
(first) (Last)

Birthdate \_\_\_\_\_

Boy Girl (please circle)

Patient's Physician \_\_\_\_\_ Phone \_\_\_\_\_

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 \_\_\_\_\_

Any food or dye allergies?   List \_\_\_\_\_

Has/Had any history of:

(please circle)

Acid Reflux Y N  
Anemia Y N  
Asthma Y N  
Autism Y N  
Bleeding Disorder Y N  
Diabetes Y N  
Eating Disorder Y N  
Emotional Problem Y N  
Epilepsy/Convulsions Y N

Fainting or Dizziness Y N  
Hearing Problem Y N  
Heart Problem Y N  
Heart Murmur Y N  
Hepatitis Y N  
HIV/AIDS Y N  
Kidney Disease Y N  
Liver Disease Y N  
Mental Disorder Y N

Rheumatic Fever Y N  
Sleep Apnea Y N  
Tuberculosis Y N  
Tumors/Cancer Y N  
Special Needs/Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Dental History

Reason for this appointment \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

For what service? \_\_\_\_\_

Do you have questions or concerns about your child's oral health? \_\_\_\_\_

Yes No  
✓ ✓ if yes:

Is Fluoride taken in any form?   \_\_\_\_\_

Adverse reaction to anesthetics?   \_\_\_\_\_

Oral Habits (thumb, pacifier...)   \_\_\_\_\_

Past injury to mouth, teeth or head?   \_\_\_\_\_

Family history of cavities?   \_\_\_\_\_

Family history of braces?   \_\_\_\_\_

Does your child snack frequently?   \_\_\_\_\_

Is your child on a special diet?   \_\_\_\_\_

★ Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

★ Reviewed By Dr. Jackson on \_\_\_\_\_