

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

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 your 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 your 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: _____

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