Childe Health – Dental History Form

Patient's Name	Sex	Nickname	Date of Birth
Parent's/Guardian Name		Relationship to Patient	
Address	City	State	Zip
Phone			
Name and Phone Number Child's physician: Name		Phone	

Has the child had any history of, or conditions related to, any of the following: Please Circle

Anemia	Cancer	Epilepsy	HIV +/ AIDS	Mononucleosis	Thyroid
Arthritis	Cerebral Palsy	Fainting	Immunizations	Mumps	Tobacco/Drug Use
Asthma	Chicken Pox	Growth Problems	Kidney	Pregnancy (teens)	Tuberculosis
Bladder	Chronis Sinusitis	Hearing	Latex allergy	Rheumatic Fever	Venereal Disease
Bleeding Disorders	Diabetes	Heart	Liver	Seizures	Other________
Bones/Joints	Ear Aches	Hepatitis	Measles	Sickle Cell	

Childs History Circle One

1- Is the child taking any prescription and/or over the counter medications or vitamins supplements at this time?..YES NO
If yes, please list:____.
2- Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs?..YES NO
If yes, please explain: ____.
3- Is the child allergic to anything else, such as certain foods?..YES NO
If yes, Please explain:____.
4- How would you describe the child's eating habits?____.
5- Has the child ever had a serious illness?..YES NO
If yes, when:______________ Please describe____.
6- Has the child ever been hospitalized?..YES NO
7- Does the child have a history of any other illnesses?..YES NO
If yes, please explain:____.
8- Has the child ever received general anesthetic?..YES NO
9- Does the child have any inherited problems?..YES NO
10- Does the child have any speech difficulties?..YES NO
11- Has the child ever had a blood transfusion?..YES NO
12- Is the child physically, mentally, or emotionally impaired?..YES NO
13- Does the child experience excessive bleeding when cut?..YES NO
14- Is the child currently being treated for any illnesses?..YES NO
15- Is this the child's first visit to a dentist?..YES NO
If not the first visit, what was the date of the last dentist visit? Date:____.
16- Has the child had any problems with dental treatment in the past?..YES NO
17- Has the child ever had dental radiographs (x-rays) exposed?..YES NO
18- Has the child ever suffered any injuries to the mouth, head or teeth?..YES NO
19- Has the child had any problems with the eruption or shedding of teeth?..YES NO
20- Has the child had any orthodontic treatment?..YES NO
21- What type of water does your child drink? Circle One: - City Water, - Well water, - Bottled water, - Filtered water
22- Does the child take fluoride supplements?..YES NO
23- Is fluoride toothpaste used?..YES NO
24- How many time are the child's teeth brushed per day?___________ When are the teeth brushed?_______________.
25- Does the child suck his/her thumb, fingers, or pacifier?..YES NO
26- At what age did the child stop bottle feeding? Age_______________ Breast feeding? Age _____________________.
27- Does the child participate in active recreational activities?..YES NO

NOTE: Both doctor and patients 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 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's/ Guardian Signature: ____Date:__________________