CHILD'S HEALTH HISTORY

Child's Full Name:_____ **Nickname/Preferred Name:**_____

Birthdate:_____ **Gender: Female**___**Male**___ **Number of Children in the Family**_____

Dental History

Is this your child's first visit to the dentist?___Yes___No…If No, Name of former Dentist:_____

Has your child had any dental fear or past unhappy dental experiences? ___Yes ___No

Has your child had any of the following:

___Tooth Pain ___Tooth Trauma___Dental treatment with oral sedation

___Facial Swelling ___Cold Sores ___Dental treatment with General Anesthesia

Does your child have any of the following habits:

___Thumb Sucking ___Pacifier Use ___Snoring ___Mouth Breathing at night

___Lip Sucking ___Lip Biting ___Nail Biting ___Other (explain):_____

How often are your child's teeth brushed? ___1/day ___2/day ___Other…….With Adult assistance? ___Yes ___No

How often are your child's teeth flossed? ___Never ___1/day ___Other……..With Adult assistance? ___Yes ___No

Does your child use any of the following: ___Fluoride Toothpaste ___Fluoride Drops/Pills ___Fluoride Mouthwash

Does your child drink tap water? ___Yes ___No……..Tap water source:___City water ___Well water ___Other

Medical History

Name of Child's Physician:_____Phone:_____

Is your child taking any medication? ___Yes ___No…If Yes, list:_____

Does your child have any allergies? ___Yes ___No…If Yes, list:_____

Has your child ever been hospitalized? ___Yes ___No…If Yes, reason:_____

Has your child had any surgeries? ___Yes ___No…If Yes, list:_____

Has your child had any history of:

___Asthma ___Autism ___Bleeding Disorder ___Chemotherapy/Radiation

___ADD/ADHD ___Diabetes ___Heart Problems ___Developmental Delay

___Hearing Difficulty ___Down Syndrome ___Kidney Problems ___Mental/Emotional Disturbance

___Speech Difficulty ___Seizure Disorder ___Liver Problems ___Cerebral/Spastic Condition

___Sleep Apnea ___HIV/AIDS ___Hepatitis ___Other

If Other, please explain:_____

Parent (guardian) Signature:_____ Date:_____

Health History Reviewed by Parent or Guardian:

Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials