

Patient Health History

Patient Name _____ Birth date: ____/____/____ Today's Date: ____/____/____

Child's Physician _____ Phone #: _____._____._____

Who May We Thank For Referring You?: _____

Purpose of Today's Visit: _____

Date of Last Dental Visit: ____/____/____ Previous Dentist: _____

Circle One

1. Does your child have any specific medical condition - tuberculosis, cancer, cerebral palsy, etc.?
If so, please specify _____ 1. Yes No
2. Does your child have any special limitations either mental or physical?
If so, please specify _____ 2. Yes No
3. Has your child ever had an operation? _____
If so, please specify _____ 3. Yes No
4. Have you ever been told by a physician that your child had/has a heart murmur, rheumatic fever, or a shunt?
At what age _____ Was a cardiogram ever done? _____ Is antibiotic coverage needed for dental work? ____ 4. Yes No
5. Does your child have asthma or breathing problems? 5. Yes No
6. Does your child have a history of seizures? 6. Yes No
7. Has your child ever tested positive for Hepatitis or HIV? If so, please specify _____ 7. Yes No
8. Does your child have any allergies to
Antibiotics 8. Yes No
Analgesics (aspirin, codeine) Yes No
Latex Yes No
Pollen, Grass, Dust Yes No
9. Is your child now taking any medicine? If so, please specify _____ 9. Yes No
10. Does your child have any learning disabilities, ADD or ADHD? If so, please specify _____ 10. Yes No
11. Has your child ever had a transfusion of whole blood or any blood products? _____ 11. Yes No
12. Does your child have any social difficulties? 12. Yes No
13. Is your child adopted? 13. Yes No
14. Is your child in foster care? 14. Yes No
15. Are parents separated, divorced, widowed or never married? (Question asked in order that
emotional status of child may be better understood.) 15. Yes No
16. Has your child had a history of thumb sucking, finger sucking, lip sucking, pacifier use or nail biting?
If so, please explain _____ 16. Yes No
17. Was your child's pregnancy or delivery abnormal in any way? 17. Yes No
18. Was your child breast fed? _____ Bottle fed? _____ Any difficulties? _____ 18. Yes No
19. Has your child ever had a prolonged fever for any reason? 19. Yes No
20. Has your child ever had any unfavorable experience in a medical or dental office? 20. Yes No
21. Has your child ever had any injuries to the teeth, mouth, head or neck?
If so, please explain _____ 21. Yes No
22. Has the child's natural parents ever had a lot of decay or crooked teeth? 22. Yes No
23. Is the child's mother or father afraid of dental care? 23. Yes No
24. Has your child had a toothache lately? _____ If yes, was the toothache after eating? _____
Did it awaken the child from sleep? _____ 24. Yes No
25. How do you think your child will react to this dental visit?
Very poor? _____ Poor? _____ Well? _____ Very Well? _____ 25. Yes No
26. Are there any other conditions or concerns not listed here?
If so, please specify _____ 26. Yes No

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

Signature of Parent or Guardian

Date: ____/____/____