*Please fill out one Health History form for **each child.**

HEALTH HISTORY

Child's Name _____ ☐ M ☐ F

Grade _____ Age _____

Child's Hobbies/Interests _____

Child's Pediatrician _____

Last Physical _____

Is your child under a physician's care now? ☐ Y ☐ N

If yes, reason _____

Immunizations up to date? ☐ Y ☐ N

Current Medications? ☐ Y ☐ N

If yes, please list _____

Allergic to Medication? ☐ Y ☐ N

If yes, please list _____

Child have allergic reaction to any of the following?

☐ Latex ☐ Other

If Other, please list _____

Has your child ever been a patient in a hospital? ☐ Y ☐ N

If yes, please explain: _____

Has your child ever been seen in an emergency room for ANY reason? ☐ Y ☐ N

If yes, please explain: _____

Is your child required to take an antibiotic/pre-med before a dental visit?

☐ Yes ☐ No

Has your child had a history or difficulty with any of the following? **Please check each box that applies**

☐ ADHD/ADD
☐ Allergies (seasonal)
☐ Adrenal Disorder
☐ Anemia
☐ Anxiety
☐ Autism
☐ Bladder
☐ Bleeding
☐ Blood Disorder
☐ Blood Pressure
☐ Blood Transfusion
☐ Bone Disorder
☐ Brain Injury
☐ Bruising
☐ Cancer
☐ Cold Sores
☐ Chemotherapy
☐ Depression
☐ Diabetes
☐ Down's Syndrome
☐ Ear Aches/Infections
☐ Eating Disorder
☐ Epilepsy
☐ Fainting
☐ Hearing
☐ Heart
☐ Hepatitis
☐ HIV/AIDS
☐ Immune System
☐ Intestine/Stomach
☐ Kidney
☐ Learning Difficulty
☐ Liver Disease
☐ Lung Disorder
☐ Physical Disability
☐ Pregnancy
☐ Premature Birth
☐ Radiation Treatment
☐ Recreational Drug Use
☐ Rheumatic Fever
☐ Seizures
☐ Sinus Problems
☐ Skin Disorder
☐ Smoking/Vaping
☐ Surgery (history)
☐ Speech Problems
☐ Thyroid Disease
☐ Tumors
☐ Tuberculosis
☐ Asthma

Last Asthma Attack: _____

☐ Other: _____

If yes to any, please explain: _____

DENTAL HISTORY

Is this your child's 1st dental visit? ☐ Y ☐ N

If no, previous dentist _____

Date of last visit _____

How was his/her experience? _____

Child's attitude towards the dentist or dental care

_____

Any injuries to teeth or mouth? ☐ Y ☐ N

Does your child have any of the following habits?

☐ Thumb/Finger ☐ Pacifier ☐ Nail Biting ☐ Lip Sucking

☐ Mouth-breathing ☐ Snoring ☐ Teeth Grinding

☐ Nursing ☐ Bottle Feeding

Is your water fluoridated? ☐ Y ☐ N

Does your child take fluoride supplements? ☐ Y ☐ N

Does your child use fluoridated toothpaste? ☐ Y ☐ N

How often does your child brush his/her teeth? _____ x/day

How often does your child floss? _____ x/day

Reason for your child's visit today

_____

DIET HISTORY

Did you or do you breastfeed your child? ☐ Y ☐ N

What age did you discontinue breastfeeding? _____

What foods does your child like for a snack? _____

_____

_____

What does your child drink on a daily basis? _____

_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any changes in health and/or medication.

Signature _____

Relationship _____ Date _____