# HEALTH HISTORY

**We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health!**

| TELL US ABOUT YOUR CHILD | | | |
|---|---|---|---|
| **CHILD'S NAME** | | | **PREFERRED NAME** |
| **DATE OF BIRTH** | ☐ **MALE** ☐ **FEMALE** | | **DESCRIBE CHILD'S TEMPERAMENT** |
| **AGE** | **GRADE** | | **HOBBIES** |

| DENTAL & MEDICAL HISTORY | | | | | |
|---|---|---|---|---|---|
| **CHILD'S PHYSICIAN** | | **PHONE #** | | **DATE OF LAST EXAM** | |
| **HAS YOUR CHILD OR DOES HE/SHE NOW HAVE ANY OF THE FOLLOWING DISEASES OR CONDITIONS?** | | | | | |
| ADD/ADHD | ☐ YES ☐ NO | BEHAVIORAL PROBLEMS | ☐ YES ☐ NO | GI PROBLEMS | ☐ YES ☐ NO |
| AIDS/HIV | ☐ YES ☐ NO | DIABETES | ☐ YES ☐ NO | KIDNEY/STOMACH DISEASE | ☐ YES ☐ NO |
| ANEMIA | ☐ YES ☐ NO | DRUG/ALCOHOL/TOBACCO USE | ☐ YES ☐ NO | LUNG DISEASE | ☐ YES ☐ NO |
| ASPERGER'S | ☐ YES ☐ NO | EAR ACHES/INFECTIONS | ☐ YES ☐ NO | LOW/HIGH BLOOD PRESSURE | ☐ YES ☐ NO |
| AUTISM | ☐ YES ☐ NO | EPILEPSY/FAINTING/SEIZURES | ☐ YES ☐ NO | RADIATION/CHEMOTHERAPY | ☐ YES ☐ NO |
| CANCER/TUMORS | ☐ YES ☐ NO | HEADACHES/MIGRAINES | ☐ YES ☐ NO | REFLUX | ☐ YES ☐ NO |
| CEREBRAL PALSY | ☐ YES ☐ NO | HEARING/SPEECH IMPAIRMENT | ☐ YES ☐ NO | SENSORY PROCESSING DISORDER | ☐ YES ☐ NO |
| CLEFT PALATE | ☐ YES ☐ NO | HEART DISEASE/MURMURS | ☐ YES ☐ NO | SINUS PROBLEMS | ☐ YES ☐ NO |
| CHILDHOOD DISEASES | ☐ YES ☐ NO | RHEUMATIC FEVER | ☐ YES ☐ NO | SKIN DISORDER | ☐ YES ☐ NO |
| CHILDBIRTH DEFECTS | ☐ YES ☐ NO | HEART VALVE REPLACEMENT | ☐ YES ☐ NO | THYROID DISEASE | ☐ YES ☐ NO |
| COLD/CANKER SORES | ☐ YES ☐ NO | HEPATITIS | ☐ YES ☐ NO | TUBERCULOSIS | ☐ YES ☐ NO |
| LEARNING DISABILITIES | ☐ YES ☐ NO | HEMOPHILIA/BLEEDING ISSUES | ☐ YES ☐ NO | VISION PROBLEMS | ☐ YES ☐ NO |
| IF YOU MARKED YES TO ANY OF THE ABOVE, PLEASE INCLUDE ADDITIONAL INFORMATION: | | | | | |

| | | |
|---|---|---|
| **ASTHMA** ☐ YES ☐ NO | Treatment | Last Used/attack |
| **ALLERGIES** ☐ YES ☐ NO | ☐ Seasonal ☐ Metal ☐ Aspirin ☐ Sulfa ☐ Local Anesthetic ☐ Latex ☐ Penicillin/Amoxicillin<br>☐ Foods: _____ ☐ Other: _____ | |
| **SURGERIES** ☐ YES ☐ NO | (Please include type and dates) | |
| **HOSPITALIZATIONS** ☐ YES ☐ NO | (Please include reason and dates) | |
| **MEDICATIONS** ☐ YES ☐ NO | (Please include type and doses) | |
| **IS YOUR CHILD ADOPTED?** ☐ YES ☐ NO | FEMALE PATIENTS: Could you be pregnant? ☐ YES ☐ NO | |
| PLEASE LIST ANY OTHER HEALTH CONCERNS: | | |

**Print Name**_____

**Signature of Parent/Guardian**_____ **Date** _____