

Patient Health History

Patient Name _____ Date of Birth _____

Age 12 and under. Welcome to our office. Will you please fill out this short Health History form so we may be aware of any problems your child may have or have had. Thank you.

Please circle YES or NO or fill in where appropriate:

Purpose for today's visit _____

Name of child's physician _____

Physician's address _____

Physician's phone number _____

Date of child's last visit to physician _____

DENTAL HISTORY...

Date of last dental examination _____

Date of last dental X-Rays _____

Has the child had a difficulties associated with previous dental treatment? Yes No

If so, explain _____

Please indicate any of the items below that apply to your child:

Injury to mouth or teeth Yes No

Oral habits: thumbsucking, nail biting Yes No

Frequent ulcers / blisters Yes No

Sensitive / painful teeth Yes No

Grinding of teeth Yes No

Bleeding gums Yes No

Recurrent / frequent headaches Yes No

Please explain any "YES" answers above

What type of water does your child drink?

City water Well Water Bottled Water Circle One

At what age did your child stop bottle feeding? Age _____ Breast Feeding? Age _____

MEDICAL HISTORY...

Has your child had any of the following medical conditions?

Heart murmur Yes No

Congenital Heart Disease Yes No

Diabetes Yes No

HIV Virus / Aids Yes No

Blood Disorder / Transfusions Yes No

Sickle Cell Anemia Yes No

Hepatitis / Jaundice Yes No

Tuberculosis	Yes	No
Convulsions / Epilepsy	Yes	No
Asthma	Yes	No
Sinus Problems	Yes	No
Rheumatic Fever	Yes	No
Cancer / Tumors	Yes	No
Kidney / Liver Problems	Yes	No
Mental Handicap	Yes	No
Physical Handicap	Yes	No
Hearing Impairment	Yes	No
Speech Impairment	Yes	No
Hyperactive	Yes	No
Premature Birth	Yes	No
Hospitalization	Yes	No
Surgeries	Yes	No

Explain any "Yes" answers above or other problems not listed: _____

List any drugs the child is now taking _____

List any drugs the child is allergic to _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the doctor and staff to perform the necessary dental services for my child

X _____
 Signature of patient or guardian Date

MEDICAL HISTORY UPDATE SIGNATURE	COMMENTS	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____