CHILD HEALTH HISTORY

PARENT/GUARDIAN: The purpose of the following is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record. Please complete this form and remain in the dental office while your child is receiving treatment.

Name: _____ Birthdate____/____/____

Child prefers to be called: _____

Date of child's last medical examination: ____/____/____ Current Height: _____feet _____inches

Reason: _____ Current Weight: _____pounds

Medical History

Pediatrician Name: _____

Address _____

_____
City State Zip

Phone #: ( ) _____

Child's current physical health is: ❑ Good ❑ Fair ❑ Poor

Is child currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

_____

Does your child use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Jewelry	Y N Seasonal
Y N Codeine	Y N Latex	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Other_____	

Please list additional drugs that cause allergic reactions: _____

_____

_____

For Women: Is child taking birth control pills? ❑ Yes ❑ No

Is child pregnant? ❑ Unsure ❑ Yes, week #:____ ❑ No

Is child nursing? ❑ Yes ❑ No

Is child taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one: _____

Please indicate if this child has ever been diagnosed or treated for any of the following:

Y N Abnormal Bleeding	Y N Emphysema	Y N Liver Disease
Y N Alcohol Abuse/Drug Abuse	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Pacemaker
Y N Arthritis	Y N Frequent/Severe Headaches	Y N Persistent Cough
Y N Artificial Bones/Joints	Y N Glaucoma	Y N Psychiatric Problems
Y N Artificial Heart Valves	Y N Hay Fever	Y N Radiation Treatment
Y N Autoimmune Disease	Y N Heart Attack	Y N Rheumatic Fever
Y N Asthma	Y N Heart Murmur	Y N Scarlet Fever
Y N Blood Transfusion	Y N Heart Surgery	Y N Sinus Problems
Y N Cancer	Y N Hepatitis Type _____	Y N Steroid Therapy
Y N Chemotherapy	Y N Herpes/Fever Blisters	Y N Stroke
Y N Colitis/Ulcers	Y N High/Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Diabetes	Y N Kidney Problems	Y N Venereal Disease
Y N Difficulty Breathing		

List any serious medical condition(s) that the child has experienced:

_____

Yes	No	
❑	❑	Was child born of a normal 9 month pregnancy? If premature, how many months?_____ Birth weight:_____lbs._____oz.
❑	❑	Is child physically or mentally handicapped in any way? If yes, how: _____
❑	❑	Does child need an update on immunizations? Has child ever received general anesthesia or sedation? ❑ Yes ❑ No
❑	❑	Is child in the grade appropriate for his/her age?

I have answered these questions for the patient (child) to the best of my knowledge and ability.

_____

Signature of parent or legal guardian Date