PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Patient's Name _____ Nickname_____ Age_____ Date of Birth_____
Last First

Date _____ Sex____ Race____ School_____ Grade_____

Parents or Responsible Guardian _____ Telephone_____
Home Work

Address _____
Number and Street City State Zip

Name of Child's Physician and clinic _____ Date last seen_____

Reason for bringing child to the dentist_____

HISTORY	**Yes**	**No**
1. Is your child being treated by a physician at this time?	☐	☐
2. Has your child ever been a patient in a hospital?	☐	☐
Or had a serious illness?	☐	☐
3. Has your child ever received general anesthesia?	☐	☐
4. Is your child allergic to anything? (medicine, food)	☐	☐
If yes, what?_____		
5. Is your child taking any medications at this time?	☐	☐
If yes, what?_____		

	Yes	**No**
6. Has your child ever been seen by a dentist before?	☐	☐
7. Has your child ever received fluoride in any form?	☐	☐
If yes, what?_____		
8. Does your child suck his/her thumb or fingers?	☐	☐
9. Are your child's teeth brushed once a day? _____times?	☐	☐
10. What type of toothpaste does your child use?_____		
11. At what age did your child stop bottle/breast feeding?_____		
12. Do you have well or city water? _____		

ORGANS AND SYSTEMS

Has this child ever had any treatment for any of the following? Please check yes or no:

☐ **This child has NOT had any treatment for the below.**

Yes	No		Yes	No		Yes	No	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency
☐	☐	Allergy	☐	☐	Eye Problems	☐	☐	Orthopedic Problems
☐	☐	Arthritis	☐	☐	Excessive Bleeding Problem	☐	☐	Pneumonia
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Polio
☐	☐	Autism	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever
☐	☐	Brain Injury	☐	☐	Heart Disease/Problems	☐	☐	Scarlet Fever
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Scoliosis
☐	☐	Cerebral Palsy	☐	☐	Hepatitis - Type_____	☐	☐	Sickle Cell Anemia
☐	☐	Chicken Pox	☐	☐	HIV Positive/AIDS	☐	☐	Spina Bifida
☐	☐	Cleft Lip/Palate	☐	☐	Jaundice	☐	☐	Syndrome_____
☐	☐	Convulsion/Seizures	☐	☐	Leukemia	☐	☐	Tetanus
☐	☐	Diabetes	☐	☐	Measles	☐	☐	Whooping Cough
☐	☐	Diphtheria	☐	☐	Mental Retardation	☐	☐	Other_____
☐	☐	Emotional Disturbance	☐	☐	Mumps			

Is there anything else we should know about your child? _____

_____

_____
Signature of person completing form Relationship to patient Date