Children's Health History Form

Child's Name: _____ Nickname: _____ Gender: _____

Birth date: ___/___/___ School: _____ Grade: ___ Home Phone (_____) _____-_____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

E-mail (***to confirm appointments***): _____

Pediatrician: _____ Phone (___) ___-_____ Other Treating Specialist: _____ Phone (___) ___-_____

Parent's Marital Status: Married Separated Divorced Remarried Widowed Single

Mother's Information Name: _____ Spouse's Name (if different than father): _____

Address (***if different than child's***): _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Father's Information Name: _____ Spouse's Name (if different than mother): _____

Address (***if different than child's***): _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Medical History

Y N Does your child have any health problems? (No matter how insignificant) _____

Y N Has your child ever been in the hospital or had surgery? Explain: _____

Y N Does your child have any allergies to food or medication? _____

Y N Does your child have, or has he/she ever had the following? (*Check all that apply*)

❑ **Heart Disorder** ❑ **Kidney Disorder** ❑ **Liver Disorder** ❑ **Seizure Disorder** ❑ **Blood Disorder**
❑ **Contagious Disease** ❑ **Chronic Condition** ❑ **Seasonal Allergies** ❑ **Hepatitis** ❑ **Asthma**
❑ **Diabetes** ❑ **Gastric Reflux** ❑ **Cancer** ❑ **HIV/TB**
❑ **None of the above** ❑ **Other, explain** _____

Y N Does your child take any medications? (If yes, please list and give reason): _____

_____

Y N Has your child ever had an unfavorable reaction to drugs, including antibiotics? (If yes, which): _____

Y N Does your child have an emotional/behavioral or learning disorder? (Please describe): _____

_____

Dental History

Y N Does your child have a history of any of the following? (*Circle any that apply*)

❑ **Pacifier** ❑ **Lip or nail biting** ❑ **Thumb or finger sucking** → **If habit has been stopped, when?** _____

Y N Has your child had a toothache recently?

Y N Has either parent had a lot of tooth decay?

Y N Are you satisfied with the appearance of your child's teeth?

Y N Does your child play sports? If yes, do they wear an athletic mouth guard? Y N

Y N Has your child seen an orthodontist? If yes, whom? _____

Y N Has anyone in your family had orthodontic treatment? If yes, whom? _____

Y N Does your child have any speech issues? (Please explain) _____

Current Oral Health Habits

Does your child receive fluoride in any of the following forms? (*Check all that apply*)

❑ **Toothpaste** ❑ **Water** ❑ **Tablets** ❑ **Vitamin drops** ❑ **Rinses** ❑ **Other**_____

Toothbrush: ❑ **Soft** ❑ **Medium** ❑ **Hard** ❑ **Electric** **Frequency per day:** _____

Do you assist your child? Y N If yes, how often? _____

Does your child floss? Y N If yes, how often? _____

Please list the snack foods that your child eats _____

Form completed by _____ Signature _____ Date ___/___/___

Dentist's Signature _____ Date ___/___/___

Children's Health History Form

Child's Name: Nickname: Gender: Birthdate: School: Grade: HomePhone) - Child's HomeAddress: City: State: Zıp: E-mail (to confirm appointments): Pediatrician: Phone - Other Treating Specialist: Phone Parent's Marital Status: Married Separated Divorced Remarried Widowed Single Mother's information Name: Spouse's Name (if different than father): Address (if different than child's): City State Zip HomePhone Work Phone ( ) Cell Phone Father's information Name: Spouse's Name (if different than mother): Address (if different than child's): City State Zip HomePhone - Work Phone) Cell Phone ( ) Medical History Y N Does your child have any health problems? (No matter how insignificant) Y N Has your child ever been in the hospital or had surgery? Explain: Y N Does your child have any allergies to food or medication? Y N Does your child have, or has he/she ever had the following? (Check all that apply) OHeart Disorder O Kidney Disorder Oliver Disorder O Seizure Disorder O Blood Disorder OContagious disease Ochronic Condition Seasonal Allergies Chepatitis OAsthma Odiabetes Gastric Reflux O Cancer oh IV/TB ONone of the above OOther, explain Y N Does your child take any medications? (If yes, please list and give reason): - Y N. Has your child ever had an unfavorable reaction to drugs, including antibiotics? (If yes, which): Y N Does your child have an emotional/behavioral or learning disorder?(Please describe): Dental History Y N Does your child have a history of any of the following? (Circle any that apply) Pacifier Olip or nail biting C Thumbor finger sucking -> If habit has been stopped, when?

has your child had a toothache recently? has either parent had a lot of tooth decay? Are you satisfied with the appearance of your child's teeth? Does your child play sports? If yes, do they wear an athletic mouthguard? Y N Has your child seen an orthodontist? If yes, whom? Has anyone in your family had orthodontic treatment? If yes, whom? Does your child have any speech issues? (Please explain)

Current Oral health habits Does your child receive fluoride in any of the following forms? (Check all that apply)

OToothpaste O. Water U) Tablets Ovitamin drops Rinses OOther Toothbrush: OSoft O Medium Chard OElectric Frequency per day: Do you assist your child? Y N if yes, how often? Does your child floss? Y N if yes, how often? Please list the snack foods that your child eats Form completed by Signature - Date / /

Dentist's Signature

Date — / /