Child Health History

Patient Name: Birth Date: Date Created:

For children 14 years or younger

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

GENERAL

Is this a first dental visit?	◉ Yes ○ No	
Have there been unpleasant medical or dental visits?	○ Yes ◉ No	
Is there a finger sucking habit?	○ Yes ○ No	
Involvement with: speech therapy, special education or physically handicapped? If yes, which program?	○ Yes ○ No	If yes
Have there been fluoride treatments?	◉ Yes ○ No	

MEDICAL HISTORY

Are you in good health?	◉ Yes ○ No	
Are you under medical treatment?	◉ Yes ○ No	
Are you taking medicine regularly? If yes, please list:	○ Yes ◉ No	If yes

Do you have or have you had:

Heart trouble	◉ Yes ○ No
High or low blood pressure	◉ Yes ○ No
Diabetes	◉ Yes ○ No
Rheumatic fever	◉ Yes ○ No
Tuberculosis	◉ Yes ○ No
Asthma	◉ Yes ○ No
Hepatitis	◉ Yes ○ No
Arthritis	◉ Yes ○ No
Allergies	◉ Yes ○ No
Bleeding problems	◉ Yes ○ No

Have you had a reaction to:

Penicillin (antibiotics)	◉ Yes ○ No
Sulfa	◉ Yes ○ No
Anesthetics like novocaine	◉ Yes ○ No
Aspirin	◉ Yes ○ No

Taking any other medications not listed above? If yes, please list:	◉ Yes ○ No	If yes

DENTAL HISTORY

Are you bothered with:

tender teeth when chewing	◉ Yes ○ No
Bleeding gums	◉ Yes ○ No
Bad breath	◉ Yes ○ No
Sore areas in your mouth	◉ Yes ○ No
Pain in or near your ears	◉ Yes ○ No
Spaces developing between teeth	◉ Yes ○ No
Sensitivity to heat, cold, sweets	◉ Yes ○ No

Have you been treated by a Periodontist	◉ Yes ○ No	
Have you been treated by an Orthodontist?	◉ Yes ○ No	
have you been treated by an Orthodontist?	◉ Yes ○ No	
have you recieved personal instruction in the care of your teeth?	◉ Yes ○ No	
Do you wish to maintain your own teeth and avoid dentures?	◉ Yes ○ No	
have missing teeth been replaced?	◉ Yes ○ No	
Date of last dental visit?		Comment

SIGNATURE

Signature of Patient, Parent or Guardian:

X

Date:_____