hild Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M F

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... Yes No
. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

Anemia	Cancer	Epilepsy	HIV +/AIDS	Mononucleosis	Thyroid
Arthritis	Cerebral Palsy	Fainting	Immunizations	Mumps	Tobacco/Drug Use
Asthma	Chicken Pox	Growth Problems	Kidney	Pregnancy (teens)	Tuberculosis
Bladder	Chronic Sinusitis	Hearing	Latex allergy	Rheumatic fever	Venereal Disease
Bleeding disorders	Diabetes	Heart	Liver	Seizures	Other_____
Bones/Joints	Ear Aches	Hepatitis	Measles	Sickle cell	

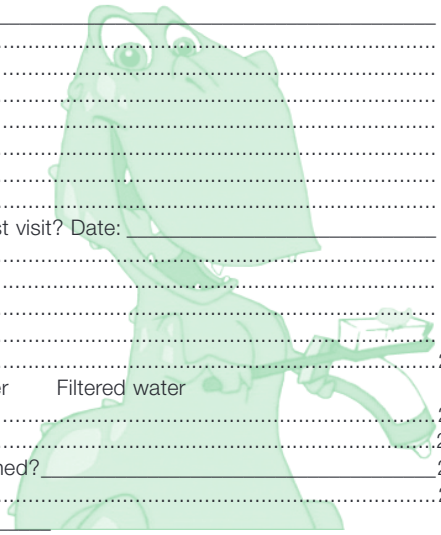
Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

hild's History

es No

. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... .
If yes, please list: _____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ 2.
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ 3.
4. How would you describe the child's eating habits? _____
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ 5.
6. Has the child ever been hospitalized? ..... 6.
7. Does the child have a history of any other illnesses? If yes, please list: _____ 7.
8. Has the child ever received a general anesthetic? ..... 8.
9. Does the child have any inherited problems? ..... 9.
0. Does the child have any speech difficulties? ..... 0.
. Has the child ever had a blood transfusion? ..... .
2. Is the child physically, mentally, or emotionally impaired? ..... 2.
3. Does the child experience excessive bleeding when cut? ..... 3.
4. Is the child currently being treated for any illnesses? ..... 4.
5. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____ 5.
6. Has the child had any problem with dental treatment in the past? ..... 6.
7. Has the child ever had dental radiographs (x-rays) exposed? ..... 7.
8. Has the child ever suffered any injuries to the mouth, head or teeth? ..... 8.
9. Has the child had any problems with the eruption or shedding of teeth? ..... 9.
20. Has the child had any orthodontic treatment? ..... 20.
21. What type of water does your child drink? City water Well water Bottled water Filtered water
22. Does the child take fluoride supplements? ..... 22.
23. Is fluoride toothpaste used? ..... 23.
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____ 24.
25. Does the child suck his/her thumb, fingers or pacifier? ..... 25.
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____
27. Does child participate in active recreational activities? ..... 27.



OTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____

Date _____

Form S707

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