CHILD'S HEALTH HISTORY

Y N Is your child adopted?

Y N Is your child currently taking any medications? If yes, please list:_____

Y N Is your child allergic to any medications? If yes, please list:_____

Y N Is your child allergic to latex products?

Y N Is your child currently under the care of a physician? (other than routine well checks)

Y N Have you ever been told your child needs premedication for a heart condition before dental treatment?

Y N Are your child's immunizations up-to-date?

Has your child ***ever*** had any of the following?:

Y	N	Abnormal bleeding	Y	N	Developmental delay	Y	N	Hospitalization or surgery
Y	N	ADD/ADHD	Y	N	Diabetes	Y	N	Kidney or bladder problems
Y	N	Anemia	Y	N	Disability/Special needs	Y	N	Liver problems
Y	N	Asthma or other lung condition	Y	N	Ear infections	Y	N	Mental delay
Y	N	Autism	Y	N	Emotional/behavioral disorder	Y	N	Pregnancy
Y	N	Brain injury	Y	N	Eye problems	Y	N	Rheumatic/scarlet fever
Y	N	Cancer	Y	N	Hearing loss or impairment	Y	N	Seasonal allergies
Y	N	Cerebral palsy	Y	N	Heart disease/defect	Y	N	Sickle Cell Anemia
Y	N	Cleft lip and/or palate	Y	N	Heart murmur	Y	N	Spina Bifida
Y	N	Congenital birth defect	Y	N	Hemophilia/any blood disorder	Y	N	Tuberculosis
Y	N	Convulsions or seizures	Y	N	Hepatitis	Y	N	Thyroid problems
Y	N	Cystic fibrosis	Y	N	HIV/AIDS			

Please explain any YES responses:_____

Dental History

Y N Is this your child's first time to the dentist? If no, please list approximate last visit_____

Name of previous dentist_____ City, state_____

Were x-rays taken?_____

Reason for today's visit_____ Is your child in pain?_____

Does/did child suck THUMB FINGERS PACIFIER ? (please circle) Age discontinued_____

Is/Was child BREAST-FED BOTTLE-FED ? (please circle) Age discontinued_____

What is your water source? PUBLIC/CITY PRIVATE/WELL MOSTLY BOTTLED REVERSE OSMOSIS SYSTEM (please circle)

I ALWAYS SOMETIMES NEVER supervise my child's brushing. (please circle)

Toothbrushing is done _____ times a day

Flossing is done ALWAYS SOMETIMES NEVER

Has your child ever been seen by an orthodontist? Y N Name_____