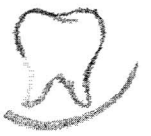
Health History



Patient's Physician _____ Phone # _____

Physician's Address _____

1. Is your child under the care of a physician for any illness or health problem? ..... ❑ Yes ❑ No

2. Does your child have or ever had any of the following health conditions?

Abnormal Bleeding Problems	❑ Yes	❑ No	Fainting	❑ Yes	❑ No
Aids or Aids Related Complex	❑ Yes	❑ No	Hearing Problems	❑ Yes	❑ No
Allergies	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No
Asthma or Other Respiratory Problems	❑ Yes	❑ No	Hepatitis, Jaundice or Liver Problems	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Artificial Limb or Implant	❑ Yes	❑ No	Hyperactivity	❑ Yes	❑ No
Bladder Disorder	❑ Yes	❑ No	Kidney Disorders	❑ Yes	❑ No
Blood Disorder	❑ Yes	❑ No	Learning Disability	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No	Mental Retardation	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Premature Delivery	❑ Yes	❑ No
Cerebral Palsy	❑ Yes	❑ No	Pregnancy	❑ Yes	❑ No
Convulsions or Seizures	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Rheumatic Fever or Heart Disease	❑ Yes	❑ No
Ear, Nose or Throat Problems	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Emotional Problems	❑ Yes	❑ No	Hyper or Hypo Thyroidism	❑ Yes	❑ No

Please explain "yes" answers _____

_____

_____

3. Does your child have any disease, syndrome or handicap not listed above? ..... ❑ Yes ❑ No

   If yes, describe _____

4. Is your child taking any over the counter drugs or prescription medications? ..... ❑ Yes ❑ No

   If yes, name of medication(s) _____

5. Has your child had any allergies or any adverse side affects to any drugs or medications, including local anesthetic, penicillin, codeine, fluoride, etc.? ..... ❑ Yes ❑ No

   If yes, name of medication(s) _____

6. Has your child ever been hospitalized? ..... ❑ Yes ❑ No

7. Has your child ever had any surgeries? ..... ❑ Yes ❑ No

8. Has your child or any relative had a problem with general anesthesia? ..... ❑ Yes ❑ No

Doctor Notes _____

_____

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Dental Information

1. Is this your child's first visit to the dentist? ..... ❑ Yes ❑ No
2. Has your child complained about dental problems? ..... ❑ Yes ❑ No
3. When was your child's last trip to the dentist? ..... ❑ Yes ❑ No

   Name of previous dentist _____
4. Has your child had an unhappy dental experience? ..... ❑ Yes ❑ No
5. Who brushes your child's teeth? _____ How Often? _____
6. Do you drink well water, city water or bottled water? _____
7. Is your child going to sleep with a bottle? ..... ❑ Yes ❑ No
8. What does the bottle contain: ❑ Water ❑ Milk ❑ Formula ❑ Juice ❑ Other
9. Is your child presently breast feeding? ..... ❑ Yes ❑ No
10. Any oral habits (thumb sucking, pacifiers, nail biting, etc.)? ..... ❑ Yes ❑ No
11. Any history of injuries to mouth, teeth, or head? ..... ❑ Yes ❑ No

    If yes, describe injury _____

The statements on both sides of this form are, to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examinations, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

_____	_____	_____
Patients Name	*Signature of Parent or Legal Guardian*	*Date*

Doctor Notes _____