DENTAL HEALTH CARE CENTER

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(612)861-7109

PEDIATRIC HEALTH HISTORY

Patient Name: ______________________ ______________________ ____ ______________________
Last | First | MI | Preferred Name

Is your child in good health? * ◯ Yes ◯ No

Please list the date of their last physical exam:

____

____

Has your child ever had a health problem? * ◯ Yes ◯ No

If yes, please describe:

____

____

Is your child allergic to anything? * ◯ Yes ◯ No

If yes, what?

____

____

Is your child currently taking any medications? * ◯ Yes ◯ No

Please give medication, dose, and reason:

____

____

Are your child's immunizations current? * ◯ Yes ◯ No

Has your child ever been hospitalized, had general anesthesia, or emergency room visits? * ◯ Yes ◯ No

Please explain:

____

____

Do you consider your child to be: *

◯ Progressing normally in the learning process ◯ Slow in the learning process

Please select if your child has been treated for any of the following:

- [ ] Heart Disease
- [ ] Asthma/breathing
- [ ] Speech/hearing
- [ ] Seizures
- [ ] Heart Murmur
- [ ] Cleft lip/Palate
- [ ] ADD/ADHD
- [ ] Congenital birth defects
- [ ] Anemia
- [ ] Diabetes
- [ ] Mental delays
- [ ] Pregnant
- [ ] Blood dyscrasias
- [ ] Snoring
- [ ] Abuse
- [ ] Tuberculous
- [ ] Frequent infections
- [ ] Cerebral palsy
- [ ] Hepatitis
- [ ] Shunts
- [ ] Cancer/Tumors
- [ ] Endocrine/Growth
- [ ] Latex Allergies
- [ ] Autism
- [ ] HIV+/AIDS
- [ ] Liver/GI Disease
- [ ] Food Allergies
- [ ] Kidney Disease
- [ ] Eyesight
- [ ] Ear Tubes
- [ ] Spina bifida
- [ ] Recurrent headaches
- [ ] Rheumatic fever
- [ ] Ear infections
- [ ] Personality/social disorder
- [ ] Tonsil/adenoid problems
- [ ] Sickle cell disease/trait
- [ ] Seasonal Allergies
- [ ] Bleeding disorder

Other

____

____

Has any member of your child's family had any of the above? If yes, please explain:

____

____

Is there any disease, condition, or problem that you think this office should know about that has not been covered? * ◯ Yes ◯ No

If yes, please describe below:

____

____

Physician Name and Phone Number:

____

____

Pharmacy Name and Phone Number:

____

____

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Dental Health Care Center of any changes in my child's medical status.

Signature ______________________________ **Date** ____________

Response Date: ____/____/________