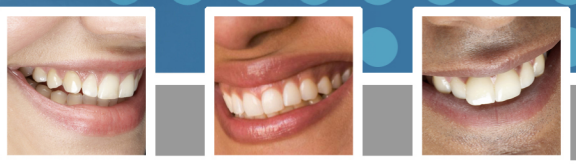
DENTAL HEALTH CARE CENTER
1717 EAST 66TH STREET
Richfield, MN 55423

(612)861-7109
appointments@dentalhealthcarecenter.com



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

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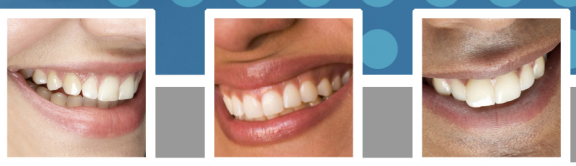

Has your child ever been hospitalized, had general anesthesia, or emergency room visits?

* ◯ 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

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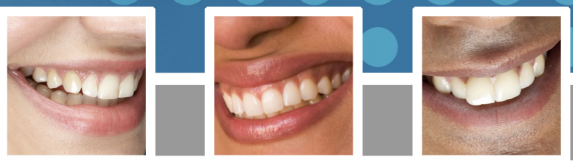

Has any member of your child's family had any of the above? If yes, please explain:

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: