

# DENTAL HEALTH CARE CENTER

1717 EAST 66TH STREET • Richfield, MN 55423

(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:

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

If yes, please describe:

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Is your child allergic to anything? \*  Yes  No

If yes, what?

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Does your child HAVE an EpiPen? \*  Yes  No

If yes, please describe:

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Does your child USE an EpiPen? \*  Yes  No

If yes, please describe:

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

Please give medication, dose, and reason:

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

If NO, please explain:

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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:

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