DENTAL HEALTH CARE CENTER

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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?

_____

_____

Does your child HAVE an EpiPen? * ◯ Yes ◯ No

If yes, please describe:

_____

_____

Does your child USE an EpiPen? * ◯ Yes ◯ No

If yes, please describe:

_____

_____

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

Please give medication, dose, and reason:

_____

_____

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

If NO, please explain:

_____

_____

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: _____