DENTAL HEALTH CARE CENTER

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PEDIATRIC HEALTH HISTORY

Patient Name: ______________________ ______________________ ___ ______________________
Last First MI Preferred Name

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, may have a critical interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Please list the date of their last physical exam (well child check) with their medical doctor: ______________________

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?

____

____

Does your child have and/or use an EpiPen? * ◯ Yes ◯ No

If yes, please describe: ______________________

Is your child currently taking any prescription medications, herbal supplements or OTC vitamins/ supplements? * ◯ Yes ◯ No

Please give medication, dose, and reason:

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Is your child up to date with all immunizations? * ◯ 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:

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Has your child had a serious head or neck injury? * ◯ Yes ◯ No

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

- [ ] Heart Disease
- [ ] Seizures
- [ ] ADD/ADHD
- [ ] Diabetes
- [ ] Frequent infections
- [ ] Cancer/Tumors
- [ ] AIDS/HIV Positive
- [ ] Eyesight
- [ ] Rheumatic fever
- [ ] Bleeding disorder
- [ ] MRSA
- [ ] Asthma/breathing
- [ ] Heart Murmur
- [ ] Birth defects/Genetic disorder
- [ ] Snoring
- [ ] Cerebral palsy
- [ ] Endocrine/Growth
- [ ] Liver/GI Disease
- [ ] Ear Tubes
- [ ] Ear infections
- [ ] Developmental problem or syndrome
- [ ] Speech/hearing
- [ ] Cleft lip/Palate
- [ ] Anemia
- [ ] Tuberculosis
- [ ] Hepatitis A, C, or B (note below)
- [ ] Autism spectrum
- [ ] Kidney Problems
- [ ] Recurrent headaches
- [ ] Tonsil/adenoid problems
- [ ] Pregnancy

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 and Pharmacy Name and Phone Number:

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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: __________