

Child Health/Dental History Form

ADA American Dental Association®

America's leading advocate for oral health

Patient's Name LAST FIRST MIDDLE INITIAL		Nickname		Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address PO OR MAILING ADDRESS				CITY	STATE
Phone HOME				ZIP CODE	
				Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? Yes <input type="checkbox"/> No <input type="checkbox"/>					
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.					
Has the child had any history of, or conditions related to, any of the following:					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/- AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teen)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
Please list the name and phone number of the child's physician:					
Name of Physician				Phone	

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized? _____	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic? _____	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems? _____	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties? _____	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion? _____	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired? _____	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut? _____	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses? _____	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past? _____	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed? _____	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth? _____	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth? _____	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment? _____	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements? _____	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used? _____	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier? _____	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities? _____	27. <input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: Medical Ref. Prescription Allergies Anesthetics Reviewed by _____
 Date _____