strohmandental

Child Health/Dental History Form

Patient's Name		Prefers to be called
DOB	Gender	Weight
Parent's/Guardian's Name		Relationship to Patient
Address		
Home Phone	Cell Phone	Work Phone

Has the child had any history of, or conditions related to, the following:

□Anemia	□Cancer	□Epilepsy	□HIV +/AIDS	□Mononucleosis	□Thyroid
□Arthritis	□Cerebral Palsy	□Fainting	□Immunizations	□Mumps	□Tobacco/Drug Use
□Asthma	□Chicken Pox	□Growth Problem	□Kidney	□Pregnancy (teens)	□Tuberculosis
□Bladder	□Chronic Sinusitis	□Hearing	□Latex allergy	□Rheumatic fever	□Venereal Disease
□Bleeding Disorders	□Diabetes	□Heart	□Liver	□Seizures	□Other _____
□Bones/Joints	□Ear Aches	□Hepatitis	□Measles	□Sickle cell	

Name of Child's Physician:_____ Phone_____

Child's History: *please circle your answer*

Is the child taking any prescription and/or over the counter medications or vitamin supplement?..... yes no
If yes, please list:_____
Is child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? ..... yes no
If yes, please explain:_____
Is the child allergic to anything else, such as certain foods?..... yes no
If yes, please explain:_____
How would you describe the child's eating habits?_____
Has the child ever had a serious illness? ..... yes no
If yes, please describe when/ what:_____
Has the child ever been hospitalized?..... yes no
If yes, please describe when/ why:_____
Does the child have a history of any other illnesses? ..... yes no
If yes please explain:_____
Has the child ever received a general anesthetic?..... yes no
Does the child have any inherited problems?..... yes no
Does the child have any speech difficulties?..... yes no
Has the child ever had a blood transfusion?..... yes no
Is the child physically, mentally, or emotionally impaired?..... yes no
Does the child experience excessive bleeding when cut?..... yes no
Is the child currently being treated for any illnesses?..... yes no
Is this the child's first visit to a dentist?..... yes no
If not, when was the child's last visit?_____
Has the child had any problem with dental treatment in the past?..... yes no
Has the child ever had dental radiographs (x-rays)?..... yes no
Has the child ever suffered any injuries to the mouth, head or teeth?..... yes no
Has the child had any problems with the eruption or shedding of teeth?..... yes no
Has the child had any orthodontic treatment?..... yes no
What type of water does your child drink? □ City water □Well water □Bottled water □Filtered water
Does the child take fluoride supplements?..... yes no
Is fluoride toothpaste used?..... yes no
How many times are the child's teeth brushed per day?_____When are the teeth brushed?_____
Does the child suck his/her thumb, fingers or pacifier?..... yes no
Does the child go to bed with a bottle or cup to drink?..... yes no
Does the child participate in sports?..... yes no

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 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 **Reviewed by:**_____

Comments_____

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