

Child Health/Dental History Form



American Dental Association
www.ada.org

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|---|--|--|---|--|
| Patient's Name <small>LAST FIRST INITIAL</small> | | | Nickname | Date of Birth |
| Parent's/Guardian's Name | | | Relationship to Patient | |
| Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small> | | | | |
| Phone <small>Home Work</small> | | | 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 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"/> Arthritis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Kidney | <input type="checkbox"/> Pregnancy (teens) |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Hearing | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Liver | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bones/Joints | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Sick cell |
| <input type="checkbox"/> Thyroid | | | | |
| <input type="checkbox"/> Tobacco/Drug Use | | | | |
| <input type="checkbox"/> Tuberculosis | | | | |
| <input type="checkbox"/> Venereal Disease | | | | |
| <input type="checkbox"/> Other _____ | | | | |
| 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 Alert Premedication Allergies Anesthesia Reviewed by _____
Date _____