Children's Health History Form

Child's Legal Name: ____ Nickname: _________________________ Gender: ______
(FIRST) (MI) (LAST)

Birth date: ____/____/____ School: __________________________________ Grade: ____ Home Phone (_____) ______-________

Child's Home Address: ____________________________________ City: ____________________ State: _______ Zip: ________

E-mail (***to confirm appointments***): ____

Pediatrician: _______________ Phone (____) ____-______ Other Treating Specialist: _______________ Phone (____) ____-_____

Parent's Marital Status: Married Separated Divorced Remarried Widowed Single

Mother's Information Name: ____________________________ Spouse's Name (if different than father): _________________

Address (***if different than child's***): ___________________________ City ____________________ State _______ Zip __________

Home Phone (______) _______-_________ Work Phone (______) _______-_________ Cell Phone (______) _______-__________

Father's Information Name: ____________________________ Spouse's Name (if different than mother): ________________

Address (***if different than child's***): ___________________________ City ____________________ State _______ Zip __________

Home Phone (______) _______-_________ Work Phone (______) _______-_________ Cell Phone (______) _______-__________

Medical History

Y N Does your child have any health problems? (No matter how insignificant) ____

Y N Has your child ever been in the hospital or had surgery? Explain: ____

Y N Does your child have any allergies to food or medication? ____

Y N Does your child have, or has he/she ever had the following? (*Check all that apply*)

- ❑ **Heart Disorder** ❑ **Kidney Disorder** ❑ **Liver Disorder** ❑ **Seizure Disorder** ❑ **Blood Disorder**
- ❑ **Contagious Disease** ❑ **Chronic Condition** ❑ **Seasonal Allergies** ❑ **Hepatitis** ❑ **Asthma**
- ❑ **Diabetes** ❑ **Gastric Reflux** ❑ **Cancer** ❑ **HIV/TB**
- ❑ **None of the above** ❑ **Other, explain** ____

Y N Does your child take any medications? (If yes, please list and give reason): ______________________________________

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Y N Has your child ever had an unfavorable reaction to drugs, including antibiotics? (If yes, which): __________________

Y N Does your child have an emotional/behavioral or learning disorder? (Please describe): ________________________

____

Dental History

Y N Does your child have a history of any of the following? (*Circle any that apply*)

❑ **Pacifier** ❑ **Lip or nail biting** ❑ **Thumb or finger sucking** → **If habit has been stopped, when?** _______

Y N Has your child had a toothache recently?

Y N Has either parent had a lot of tooth decay?

Y N Are you satisfied with the appearance of your child's teeth?

Y N Does your child play sports? If yes, do they wear an athletic mouth guard? Y N

Y N Has your child seen an orthodontist? If yes, whom? ____

Y N Has anyone in your family had orthodontic treatment? If yes, whom? ___________________________________

Y N Does your child have any speech issues? (Please explain) ____

Current Oral Health Habits

Does your child receive fluoride in any of the following forms? (*Check all that apply*)

❑ **Toothpaste** ❑ **Water** ❑ **Tablets** ❑ **Vitamin drops** ❑ **Rinses** ❑ **Other**________

Toothbrush: ❑ **Soft** ❑ **Medium** ❑ **Hard** ❑ **Electric** **Frequency per day:** ________

Do you assist your child? Y N If yes, how often? ______________________

Does your child floss? Y N If yes, how often? ______________________

Please list the snack foods that your child eats ____

Form completed by __________________________________ Signature _________________________________ Date ___/___/___

Dentist's Signature ____ Date ___/___/___