HEALTH HISTORY

Patient Name: _____

Child's Physician (Office and Doctor's Name) _____

Phone Number of Physician's Office _____ Date of Last Physical _____

Are Immunizations Up to Date? ☐ Yes ☐ No Is Your Child in General Good Health? ☐ Yes ☐ No

Has Your Child Ever Been Hospitalized or Had Any Kind of Surgery? ☐ Yes ☐ No If so, Please explain and give date _____

_____

Is Your Child **Allergic** to any Antibiotics/Drugs? ☐ Yes ☐ No If Yes, Please Explain What and What Type of Reaction _____

_____

Is Your Child **Allergic** to Anything Else (i.e: latex, dyes, etc)? ☐ Yes ☐ No If Yes, Please Explain What and What Type of Reaction

_____

Please check yes or no if your child has been diagnosed or treated for any of the following:

	YES	NO		YES	NO		YES	NO
ASTHMA	☐	☐	HEART DISEASE TYPE _____	☐	☐	BLEEDING DISORDERS	☐	☐
ENIRONMENTAL /SEASONAL ALLERGIES	☐	☐	LIVER DISEASE TYPE _____	☐	☐	ANEMIA TYPE _____	☐	☐
ADHD/ADD	☐	☐	KIDNEY DISEASE TYPE _____	☐	☐	SEIZURES/EPILEPSY	☐	☐
AUTISM SPECTRUM DISORDER	☐	☐	CANCERS/TUMORS TYPE _____	☐	☐	DIABETES TYPE _____	☐	☐
DOWN'S SYNDROME	☐	☐	PERSONALITY/SOCIAL DISORDERs	☐	☐	HEPATITIS TYPE _____	☐	☐
CEREBRAL PALSY	☐	☐	VISION PROBLEMS	☐	☐	AIDS/HIV	☐	☐
CLEFT LIP/PALATE	☐	☐	ACID REFLUX/GERD	☐	☐	SPEECH/HEARING DIFFICULTIES	☐	☐
MENTAL DELAYS	☐	☐				EATING DISORDERS	☐	☐
PHYSICAL DELAYS	☐	☐						
NEUROLOGICAL PROBLEMS	☐	☐						

OTHER (NOT LISTED) _____

PLEASE ELABORATE ON ANY MEDICAL INFORMATION MARKED _____

Is There Any Significant Family History Of Diseases /Oral Cancers? ☐ Yes ☐ No Explain:_____

Is Your Child Currently Taking Any Medications? ☐ Yes ☐ No If Yes, Please Explain Below

Drug Name _____ Dosage/Frequency _____ Reason _____

Drug Name _____ Dosage/Frequency _____ Reason _____

DENTAL HISTORY

Are There Any Specific Concerns/Questions Regarding Your Child's Mouth/ Teeth?_____

Has Your Child Ever Suffered Any Injuries to The Mouth or Teeth? ☐ Yes ☐ No If Yes, Please Explain _____

_____

Has Your Child Ever Seen a Dentist? ☐ Yes ☐ No If So, Name of Dentist and Date of Last Exam _____

Has your child previously had a negative experience at the dentist? ☐ Yes ☐ No If So, Please Explain_____

_____

Is There Anything You Can Tell Us To Help "Connect" With Your Child?
(i.e: Princesses, Trains, Spiderman, Family dog, etc.)_____

Does your child currently do any of the following? (please check all that apply):

☐ Breast Feed ☐ Bottle Feed ☐ Grind ☐ Thumb/Finger Suck ☐ Use a Pacifier ☐ NONE

What Type of Water Is Present In Your Home?

☐ Filtered Water (from the tap or fridge) ☐ Reverse Osmosis ☐ Well Water ☐ Bottled Water

Does Your Child Use Fluoride Toothpaste? ☐ Yes ☐ No Any Other Forms Of Fluoride? (Rinse,Vitamins, etc.)_____