1712 5/09

## Child Health Questionnaire

*In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.*

Date ______/______/______

Child's Name ______________________ Child's Soc. Sec. No. ______________

Birthdate ____/____/____ Age ______ Sex ______ Nickname ______________

Father's Name ______________ Mother's Name ______________

Favorite Pet or Toy ______________ Pet's Name ______________

Is Child Adopted? Yes ☐ No ☐ Legal Guardian's Name ______________

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Child's Physician ______________________ Phone ______________

Date of Last Physical Examination ______________

How is your child's general health? ______________

Has your child had any serious illness? Yes ☐ No ☐

If yes, describe: ______________

Has your child ever been hospitalized? Yes ☐ No ☐

For what reason? ______________

Is you child receiving any medication at this time? Yes ☐ No ☐

If yes, describe: ______________

Has your child ever had an allergic reaction to the following

Dental Anesthetics ☐ Antibiotics ☐ Food ☐ Drugs ☐ Latex ☐

Please describe: ______________

Has your child ever received a blow or injury to his head or teeth? Yes ☐ No ☐

Describe: ______________

Has your child ever been treated with X-ray or radiation therapy? Yes ☐ No ☐

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Has your child ever had any of the following conditions? *Please check:*

| | Yes | No | | | Yes | No | | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | Age ____ | Aids or HIV | ☐ | ☐ | Age ____ | TB (Tuberculosis) | ☐ | ☐ | Age ____ |
| Heart Murmur | ☐ | ☐ | Age ____ | Bleeding Problems | ☐ | ☐ | Age ____ | Sickle Cell Anemia | ☐ | ☐ | Age ____ |
| Rheumatic Fever | ☐ | ☐ | Age ____ | Lung Disease | ☐ | ☐ | Age ____ | *Circle* Disease *or* Trait | | | |
| Diabetes | ☐ | ☐ | Age ____ | Liver Disease | ☐ | ☐ | Age ____ | Other *(Please describe):* ________ | | | |
| Scarlet Fever | ☐ | ☐ | Age ____ | Learning Disability | ☐ | ☐ | Age ____ | ________ | | | |
| Kidney Disease | ☐ | ☐ | Age ____ | Emotional Disturbance | ☐ | ☐ | Age ____ | ________ | | | |
| Epilepsy | ☐ | ☐ | Age ____ | Mental Retardation | ☐ | ☐ | Age ____ | ________ | | | |
| Asthma | ☐ | ☐ | Age ____ | Mononucleosis | ☐ | ☐ | Age ____ | ________ | | | |
| Hepatitis | ☐ | ☐ | Age ____ | Hearing Problems | ☐ | ☐ | Age ____ | ________ | | | |

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Does your child have any habits we should know about, such as:

Poor Eating Habits ☐ Thumb Sucking ☐ Pacifier ☐ Bottles ☐ Other ______________

Does your child receive fluoride in: Drinking Water at Home Yes ☐ No ☐ By Prescription Yes ☐ No ☐

Has your child had any unpleasant dental experiences? Yes ☐ No ☐

How can we help? ______________

Date of last dental examination ____/____/____

Has your child ever had orthodontic treatment? Yes ☐ No ☐ When? ______________

What is the nature of today's visit? Regular Exam ☐ Emergency ☐ State Problem: ______________ Other ☐ ________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

**I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.**

Signature of Parent or Guardian: ______________________

Signature of Doctor/Staff ______________________

*Welcome and thank you for letting us care for your child's smile!*

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**CHILD HEALTH HISTORY** **NAME** ______________ **#** ________