

Smiling Faces Pediatric Dentistry

HEALTH HISTORY

Patient's Name: _____
(first) (middle) (last)

Does your child have any hobbies or special interests? Yes / No
If yes, what are they? _____

Please answer the following questions (circle one):

Is your child in good health? Yes / No
Does your child have regular medical exams? Yes / No
Are your child's immunizations current? Yes / No
Is your child currently taking medication? Yes / No
If yes, what? _____
Has your child experienced any unfavorable reactions to any medications? Yes / No
If yes, which ones? _____
Is your child undergoing medical treatment? Yes / No
If yes, for what? _____
Has your child ever been hospitalized? Yes / No
Date: _____ Reason(s): _____
Is this your child's first dental visit? Yes / No
If not, date of last dental care: _____
Has your child had an unfavorable experience in the dental office? Yes / No
If yes, please explain _____
Is your child currently experiencing any dental problems? Yes / No
If yes, what? _____
Purpose of this visit? _____

Please check the following items that may pertain to your child:

<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Lung Problem
<input type="checkbox"/> Allergies	<input type="checkbox"/> Liver Problem
<input type="checkbox"/> Kidney Problem	<input type="checkbox"/> Emotional Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Autism
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Brain Injury
<input type="checkbox"/> Asthma	<input type="checkbox"/> Retardation
<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Speech Disorder (medical)	<input type="checkbox"/> Hearing Disorder
<input type="checkbox"/> Vision Disorder	<input type="checkbox"/> other _____

Thank you for your help. Is there any additional information that might be of use to us in treating your child? _____

Signature: _____ Date: _____