CHILD'S HEALTH HISTORY Date_____

Name: _____DOB _____Height _____ Weight _____

Address_____

Telephone _____ Parent's Name _____

Parent's Cell #_____ Parent's work # _____

Hobbies, Sports, and Interests _____

DENTAL HISTORY

Chief oral complaint _____ Date of last dental exam _____

Any previous unfavorable dental experience?____yes ____ no If yes explain _____

_____

Does your child have or use any of the following? **Please answer yes or no**

____ traumatic injury to mouth or teeth	_____bad breath	_____complications from extractions
____ sensitive to hot, cold, sweet, pressure	_____ bleeding gums	_____ topical fluoride treatment
____clenching or grinding of teeth	_____ mouth breathing	_____orthodontic treatment
____swelling or lumps in mouth	_____well balanced diet	_____ fluoride supplements
____ between meal snacks	_____ pain around ear	_____frequent blisters on lips or mouth
____food impaction	_____ disclosing tablets	_____oral habits:thumbsucking, finger
____dental floss	or solution	nail biting, cheek biting, etc.

texture of toothbrush _____soft _____ med _____hard frequency of brushing _____ times per day

Does your child have a history of any of the following? **Please answer yes or no**

_____allergy to penicillin	_____hay fever or allergies in general	_____sinus problems	_____tonsillitis
_____allergy to other drugs	_____liver problems or hepatitis	_____ kidney problems	_____diabetes
_____allergy to anesthetics	_____malignancies or leukemia	_____ulcer or colitis	_____asthma
_____any heart ailments	_____anemia or blood problems	_____radiation treatments	
_____thyroid disorders	_____physical or mental handicap	_____rheumatic fever	
_____eye disorders	_____psychiatric care/emotional prob	_____excessive bleeding from cut/extract	
_____extreme nervousness or apprehension		_____immune system disorders	
_____ other		(AIDS,HIV,ARC)	

Describe any current or previous medical treatment or condition including medications taken, that is not listed above:

_____ _____

Signature-(parent or guardian) date