CHILD'S HEALTH AND DENTAL HISTORY

Child's Name last _____ first _____ Age _____ Date of Birth _____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone (____) ____-____

_____

Please list any medications or prescriptions: _____

Please describe any hospitalizations or surgery: _____

If any allergies, please describe: _____

If any history of a heart murmur, please describe: _____

Have you been told that your child requires pre-medication for dental visits: _____

Has child had any history of or difficulty with any of the following (check if yes):

☐ ADHD	☐ Anemia	☐ Asthma	☐ Bladder	☐ Cerebral Palsy
☐ Convulsions	☐ Diabetes	☐ Epilepsy	☐ Fainting	☐ Hearing
☐ Heart	☐ Kidney	☐ Liver	☐ Malignancy	☐ Mononucleosis
☐ Recent Fever	☐ Rheumatic fever			

Please describe any current medications, medical conditions, recent illnesses, or other information that we should be aware of:

_____

_____

DENTAL HISTORY

Please describe any current dental concerns _____

_____

Is your child taking a fluoride supplement? ☐ NO ☐ YES

Additional Comments: _____

_____

This information was given by:

_____ Today's date _____
(signature)

_____ Relation to child _____
(printed name)

The above information was reviewed and updated by parent/guardian/responsible adult on:

_____ by: _____ _____
(date) *(printed name)* *(signature)*

_____ by: _____ _____
(date) *(printed name)* *(signature)*

_____ by: _____ _____
(date) *(printed name)* *(signature)*