CHILD HEALTH HISTORY

PARENT/GUARDIAN: The purpose of the following is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record. Please complete this form and remain in the dental office while your child is receiving treatment.

Date of child's last medical examination: _____/_____/_____ Current Height: __________________feet _________________inches

Reason: ____Current Weight: __________________pounds

Name of child's physician:____

Medical History

Yes No

❑ ❑ Is the child taking any medications now, including birth control pills, aspirin, tylenol? Please list: ______________________

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❑ ❑ Is the child being treated by a physician now?

❑ ❑ Has the child ever taken the prescription diet drug: ❑ Fen-phen ❑ Redux ❑ Pondimin?

❑ ❑ Has the child ever had any injuries to the face or jaw? Please list: ____

❑ ❑ Does the child bleed excessively with cuts or dental extractions?

❑ ❑ If female, is the child pregnant? Due date: ______________________

❑ ❑ Is the child allergic to any of the following? *(If yes, check all that apply)*

❑ Latex rubber ❑ Sulfa ❑ Penicillin ❑ Iodine ❑ Aspirin ❑ Codeine ❑ Dental Anesthetics

❑ ❑ Is the child allergic to other medicines not listed? Please list: ____

❑ ❑ Is the child allergic to any foods? Please list: ____

Please indicate if this child has been diagnosed or treated for any of the following:

(circle)	**Year**		*(circle)*	**Year**		*(circle)*	**Year**	
Y N	________	Heart Disease	Y N	________	Kidney Disease	Y N	________	Alcohol Dependency
Y N	________	Heart Murmur	Y N	________	A-V Shunt (Kidney dialysis)	Y N	________	Drug Dependency
Y N	________	Rheumatic Fever	Y N	________	Asthma	Y N	________	Convulsions/Seizures
Y N	________	Artificial Bones/Joints	Y N	________	Lung Problems	Y N	________	Stroke
Y N	________	Implants	Y N	________	Tuberculosis (TB)	Y N	________	Epilepsy
Y N	________	HIV+/AIDS	Y N	________	Bloody/Productive Cough	Y N	________	Oral Herpes
Y N	________	Cancer	Y N	________	Unexplained Weight Loss	Y N	________	Syphilis, G.C.
Y N	________	Radiation Therapy	Y N	________	Unexplained Appetite Loss	Y N	________	Mental Disorder
Y N	________	Lupus	Y N	________	Unexplained Fevers	Y N	________	Nervous Disorder
Y N	________	Hodgkins	Y N	________	Night Sweats	Y N	________	Stomach Ulcers
Y N	________	Diabetes	Y N	________	Arthritis	Y N	________	Hemophilia
Y N	________	Pacemaker	Y N	________	Thyroid Disorder	Y N	________	Other Bleeding Disorder
Y N	________	High/Low Blood Pressure	Y N	________	Hepatitis Type _______	Y N	________	Blood Transfusion

Yes No

❑ ❑ Was child born of a normal 9 month pregnancy? If premature, how many months?______ Birth weight:______lbs.______oz.

❑ ❑ Has child ever been hospitalized? Date and reason: ____

❑ ❑ Is child physically or mentally handicapped in any way? If yes, how: ____

❑ ❑ Does child need an update on immunizations? Has child ever received general anesthesia or sedation? ❑ Yes ❑ No

❑ ❑ Is child in the grade appropriate for his/her age?

I have answered these questions for the patient (child) to the best of my knowledge and ability.

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Signature of parent or legal guardian Date