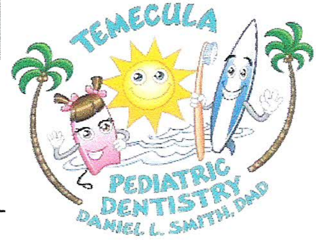
Health History Form



Child's Full Name: ______________________________ Birthdate: ____/____/_____

□ Male □ Female School: __________________________Grade: ______ Age: _____

Child's Physician: __________________________ Last Physical Date: ____________________

Patient's Hobbies, Interests, Pets, etc: ____

Other siblings and their ages: ____

Reason for visiting us today: □ Checkup □ Decay □ Habit □ Orthodontics □ Emergency □ Other:_________________

YES NO Is your child under the care of a physician for anything other than routine care?
If yes, please explain: ____

YES NO Does your child have a heart murmur, artificial valve, prosthetic joint, or any other foreign materials/objects?
If yes, please circle which one. If your child has a heart murmur, who diagnosed it? _____________________

YES NO Does your child have any drug allergies or has your child ever had a reaction to a drug?
If yes, please list the drug(s) and the reaction(s): ____

YES NO Does your child take any medication on a regular basis?
If yes, please list: ____

YES NO Is your child taking any medication at this time that he/she does not normally take on a regular basis?
If yes, please explain: ____

YES NO Has your child EVER been a patient in a hospital?
If yes, please explain: ____

YES NO Has your child EVER been seen in an emergency room for ANY reason?
If yes, please explain: ____

YES NO Does your child have or does anyone in your family have a condition called methylenetetrahydrofolate reductase deficiency (MTHFR) or hyperhomocysteninemia?

Please circle any condition your child currently has or has ever had:

Abnormal Bleeding	Bone Disorder	Epilepsy	Liver Disease	Skin Disorder
Adrenal Disorder	Brain Disorder	Hearing Problem	Lung Disorder	Speech Problem
Allergy	Breathing Problem	Heart Condition	Mental Retardation	Stomach Problem
Asthma	Cancer	Hepatitis	Muscle Disorder	Tumor
Autism	Congenital Birth Defect	HIV Positive/AIDS	Nose/Throat Disorder	Other:____________
Behavior Problem	Diabetes	Intestinal Problem	Physical Handicap	________________
Blood Disease	Ear/Eye Disorder	Kidney Problem	Pregnancy	
Blood Transfusion	Endocrine Problem	Learning Difficulty	Seizures	

YES NO Has your child ever seen a children's dentist before? If yes, approximate date of last exam: ________________

YES NO Has your child ever been seen by a regular dentist before? If yes, approximate date of last exam: ______________

YES NO Do you expect your child to be uncooperative?

YES NO Does your child drink unfluoridated water?

YES NO Does your child take fluoride tables, fluoride drops, or vitamins which contain fluoride?

YES NO Has your child ever bumped any teeth? If so, when: ____

YES NO Has your child ever experienced facial pain or had problems with the jaw joints near each ear?

YES NO Is your child a "toothpaste eater?"

YES NO Has your child had a traumatic medical or dental experience?
If yes, please explain: ____

YES NO Would you consider your child to be a slow learner?

YES NO Does your child suck his/her thumb, finger(s), pacifier, blanket, lip, something else? If yes, what: ______________

YES NO Does your child have difficulty breathing through the nose with his/her mouth closed?

YES NO Is there anything else you would like us to know or that we need to know about your child? ________________

YES NO Young children only: Does your child have a bottle to go to sleep?

The above medical, dental, and medication history is complete and accurate to the best of my knowledge.
I will notify you of ANY changes to the patient's health history prior to ANY appointment.

Signed (Parent/Guardian: ____Date:________________