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Pediatric Dentistry
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Health History Form

Last Name_____ First Name_____ Nick _____ Sex M / F Birth Date _____

SSN ___-____-_____ Father_____ Mother_____

Address_____ City, State _____ Zip _____

Phone (Home) _____(Cell)_____ Phone (Work) _____

Child's physician_____ Phone_____

Mother's Work _____ Father's Work _____

Medical History

Yes No

- ☐ ☐ Does your child have any health problems? _____
- ☐ ☐ Is your child currently under medical care? _____
- ☐ ☐ Has your child been hospitalized? _____
- ☐ ☐ Has your child been treated in an Emergency Room?_____
- ☐ ☐ Is your child allergic to anything?_____
- ☐ ☐ Has your child had an unfavorable reaction to any medicine? _____
- ☐ ☐ Does your child have any emotional, nervous, or mental disorders? _____
- ☐ ☐ Does your child take any medicines? List _____
- ☐ ☐ Were there any problems at birth? _____
- ☐ ☐ Please check if your child has had any of the following:

☐ Heart Disease	☐ Kidney Disease	☐ Bruise Easily	☐ Arthritis
☐ Heart Murmur	☐ Hearing Problems	☐ Anemia	☐ G. I. Reflux
☐ Bleeding	☐ Tuberculosis	☐ Diabetes	☐ Seizures
☐ Cleft Lip / Palate	☐ Liver Disease	☐ Hepatitis	☐ Developmental Disabilities
☐ Immune Problems	☐ Asthma	☐ AIDS / HIV	
☐ Rheumatic Fever	☐ Speech Problems	☐ Breathing Problems	

☐ Other _____

Dental History

Yes No

Purpose of today's visit?_____
Who may we thank for referring you to our office?_____
Please list their address _____

- ☐ ☐ Has your child had trouble with any previous dental treatment? _____
  _____
- ☐ ☐ Has your child ever injured his/her mouth or jaw? _____
- ☐ ☐ Does your home water have fluoride in it?
- ☐ ☐ Do you give your child fluoride supplements?
- ☐ ☐ Was your child bottle fed? If yes, age it was completely stopped? _____
- ☐ ☐ Was your child breast fed? If yes, age it was completely stopped? _____
- ☐ ☐ Has your child sucked any fingers, thumbs, pacifiers? How long? _____
- ☐ ☐ Please check if your child has problems with any of the following:

☐ Cavities	☐ Crooked Teeth	☐ Color of Teeth	☐ Sensitivity to Hot/Cold
☐ Toothache	☐ Gum Infection	☐ Bumped Teeth	☐ Sensitivity to Sweets
☐ Frequent sores	☐ Other Dental Problems _____		

Signature _____ Date _____