Child Health History

Date: ______________________________

Child's Name: ______________________ Nickname: ______________________________

Date of Birth: ______________________

Child's Address: ____

____

Child's Phone Number: ____

Emergency Contact Name: ____________________________ Number: _______________

Relationship to Child: ____

Father's Name: _____________________ Mother's Name: _______________________

Favorite Toy: ______________________ Pet's Name: ___________________________

Child's Physician: __________________ Phone: _________________________________

Date of Last Physical Exam: ____

How is your child's general health? ____

Has your child had any serious illnesses? Yes No

If yes, please describe: ____

Has your child ever been hospitalized? Yes No

If yes, please describe: ____

Has your child ever had an allergic reaction to any of the following?

____ Dental Anesthetics ____ Food

____ Antibiotics ____ Latex

If yes to any of the above, please list and describe: ________________________________

____

List medication your child is taking (include prescription and non-prescription, over the counter, vitamins, etc.): ____

____

Shumway Dental

Has your child ever had any of the following?

____ Heart Disease
____ Heart Murmur
____ Rheumatic Fever
____ Diabetes
____ Scarlet Fever
____ Kidney Disease
____ Epilepsy
____ Asthma
_____ Hepatitis
_____ Aids or HIV
_____ Bleeding Problem
_____ Lung Disease
_____ Liver Disease
_____ Mononucleosis
_____ TB (Tuberculosis)
_____ Sickle Cell Anemia

Does your child have any habits we should know about?

____ Poor Eating
____ Thumb Sucking
____ Pacifier
____ Bottles
____ Other: ____

If yes to any of the above, please list and describe: ______________________

____

Does your child receive fluoride in any of the following?

____ Drinking Water
_____ Prescription

Date of last dental examination: ________________________________

Has your child ever had orthodontic work? Yes No

If yes, when____

What is the nature of today's visit?

Regular Exam: Yes No Emergency: Yes No

If emergency, please state problem: ______________________________

____

____

Signature of Parent or Guardian

______________________ __________

Signature of Doctor Date