

Child Health History

Date: _____ Nickname: _____

Child's Name: _____

Date of Birth: _____ Phone Number: _____

Child's Address: _____

Emergency Contact Name: _____ Number: _____

Email: _____

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

_____ Antibiotics

_____ Food

_____ Latex

Shumway Dental

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.): _____ Has your child ever had any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Aids or HIV |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> 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?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Drinking Water | <input type="checkbox"/> 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

Date

Signature of Doctor

Date