Time 8:26 AM | First Dental Of West Chester | Date 5/6/2015

# Child Health/Dental History Form

Patient Name: | Birth Date: | Date Created:

Patient's Name_____ Nickname_____ Date of Birth _____Sex: ___M ___F

Parent's/Guardian's Name_____ Relationship to Patient_____

Have you (the parent/guardian) or the patient had any of the following diseases or problems?

1. Active Tuberculosis ○ Yes ○ No
2. Persistent cough greater than three-weeks ○ Yes ○ No
3. Cough that produces blood ○ Yes ○ No

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or condition related to, any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Arthritis | ☐ Asthma | ☐ Bladder |
| ☐ Bleeding/Joints | ☐ Cancer | ☐ Cerebral Palsy | ☐ Chicken Pox |
| ☐ Chronic Sinusitis | ☐ Diabetes | ☐ Ear Aches | ☐ Epilepsy |
| ☐ Fainting | ☐ Growth Problems | ☐ Hearing | ☐ Heart |
| ☐ Hepatitis | ☐ HIV +/AIDS | ☐ Immunizations | ☐ Kidney |
| ☐ Latex allergy | ☐ Liver | ☐ Measles | ☐ Mononucleosis |
| ☐ Mumps | ☐ Pregnancy (teens) | ☐ Rheumatic fever | ☐ Seizures |
| ☐ Sickle cell | ☐ Thyroid | ☐ Tobacco/Drug Use | ☐ Tuberculosis |
| ☐ Venereal Disease | ☐ Other_____ | | |

Child's History

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ○ Yes ○ No

Is the child allergic to anything else, such as certain foods? If yes, please explain: ○ Yes ○ No

Has the child ever been hospitalized? ○ Yes ○ No

Has the child ever received a general anesthetic? ○ Yes ○ No

Does the child have any speech difficulties? ○ Yes ○ No

Is the child physically, mentally, or emotionally impaired? ○ Yes ○ No

Is the child currently being treated for any illnesses? ○ Yes ○ No

Has the child had any problem with dental treatment in the past? ○ Yes ○ No

Has the child ever suffered any injuries to the mouth, head or teeth? ○ Yes ○ No

Has the child had any orthodontic treatment? ○ Yes ○ No

Is fluoride toothpaste used? ○ Yes ○ No

Does child participate in active recreational activities? ○ Yes ○ No

Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ○ Yes ○ No

Has the child ever had a serious illness? If yes, please describe and when: ○ Yes ○ No

Does the child have a history of any other illnesses? If yes, please list: ○ Yes ○ No

Does the child have any inherited problems? ○ Yes ○ No

Has the child ever had a blood transfusion? ○ Yes ○ No

Does the child experience excessive bleeding when cut? ○ Yes ○ No

Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ○ Yes ○ No

Has the child ever had dental radiographs (x-rays) exposed? ○ Yes ○ No

Has the child had any problems with the eruption or shedding of teeth? ○ Yes ○ No

Does the child take fluoride supplements? ○ Yes ○ No

Does the child suck his/her thumb, fingers or pacifier? ○ Yes ○ No

What type of water does your child drink?

☐ City Water ☐ Well water ☐ Bottled water ☐ Filtered water

At what age did the child stop bottle feeding? Age _____ Breast feeding? Age_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not because of errors of omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian:

X Date:_____