CHILDRENS HEALTH HISTORY

Date__________

____ ______________________
Name Age Birthdate

Medical Doctor________________________________ Date of last exam____________

Doctor's Address____

Phone (____) ____________________________

Do you have, or have you had any of the following? Please 'X'

____Heart Problems
____Rheumatic Fever
____Scarlet Fever
____Heart Murmur
____Immune System disorders (including AIDS, HIV, ARC)
____Hepatitis
____Diabetes
____Tuberculosis
____Nervous Problems
____Anemia
____Epilepsy
____Excessive Bleeding
____Venereal Disease

Has this child been told they need to take pre-med before the appointment?

Any Allergies to foods or Drugs____

____

Are you currently taking any medications.........Yes_____ No_____?

____

DENTAL HISTORY

Are you having any discomfort at this time? ______________________________________

How long since your last dental visit? ____________________________

Do you have, or have you ever had any of the following? Please 'X'

____Loose teeth
____Sensitive to Hot
____Sensitive to cold
____Sensitive to sweets
____Sensitive to Biting
____Burning tongue/lips
____Clenching/Grinding
____Unhappy dental experiences
____Bleeding, sore gums
____Clicking/popping jaw
____Lumps in mouth

Do you have any objection to our taking cavity-detecting x-rays whenever diagnosed necessary?
___Yes ___No

Do you have any objection to an in-office fluoride treatment every six months?
___Yes ___No

PLEASE MARK WITH "X" IF APPLICABLE

____TAKING ORAL CONTRACEPTIVES

-------PREGNANT AT THIS TIME