

Today's Date \_\_\_\_\_

# Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information that we create, receive or maintain. Your answers are for our records and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ If a child, both parents' names \_\_\_\_\_  
 Spouse's name \_\_\_\_\_ Person responsible for account \_\_\_\_\_

**Please fill out on yourself** (If a child, please fill out both parents)      **Please fill out on spouse**

**NAME** \_\_\_\_\_      **NAME** \_\_\_\_\_

Employer \_\_\_\_\_      Employer \_\_\_\_\_

Position \_\_\_\_\_      Position \_\_\_\_\_

Business Phone \_\_\_\_\_      Business Phone \_\_\_\_\_

Dental Insurance name \_\_\_\_\_      Dental Insurance name \_\_\_\_\_

Group or Employee No. \_\_\_\_\_      Group of Employee No. \_\_\_\_\_

Social Sec. No. \_\_\_\_\_      Social Sec. No. \_\_\_\_\_

Birthdate \_\_\_\_\_      Birthdate \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Name of nearest relative not living with you? \_\_\_\_\_ Phone # \_\_\_\_\_

Have you (the parent/guardian) or the patient had any of the following diseases or problems? .....  Yes  No  
 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?  
**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 conditions related to, any of the following:**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	

**Please list the name and phone number of the child's physician:**

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Child's History

- |  | Yes                          | No                       |
|--|------------------------------|--------------------------|
| 1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .....<br>If yes, please list: _____   | 1. <input type="checkbox"/>  | <input type="checkbox"/> |
| 2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____   | 2. <input type="checkbox"/>  | <input type="checkbox"/> |
| 3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____  | 3. <input type="checkbox"/>  | <input type="checkbox"/> |
| 4. How would you describe the child's eating habits? _____   |                              |                          |
| 5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____  | 5. <input type="checkbox"/>  | <input type="checkbox"/> |
| 6. Has the child ever been hospitalized? .....   | 6. <input type="checkbox"/>  | <input type="checkbox"/> |
| 7. Does the child have a history of any other illnesses? If yes, please list: _____  | 7. <input type="checkbox"/>  | <input type="checkbox"/> |
| 8. Has the child ever received a general anesthetic? .....   | 8. <input type="checkbox"/>  | <input type="checkbox"/> |
| 9. Does the child have any inherited problems? .....   | 9. <input type="checkbox"/>  | <input type="checkbox"/> |
| 10. Does the child have any speech difficulties? .....   | 10. <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the child ever had a blood transfusion? .....  | 11. <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is the child physically, mentally, or emotionally impaired? .....  | 12. <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does the child experience excessive bleeding when cut? .....   | 13. <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is the child currently being treated for any illnesses? .....  | 14. <input type="checkbox"/> | <input type="checkbox"/> |
| 15. 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: _____   | 15. <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has the child had any problem with dental treatment in the past? .....   | 16. <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has the child ever had dental radiographs (x-rays) exposed? .....  | 17. <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has the child ever suffered any injuries to the mouth, head or teeth? .....  | 18. <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has the child had any problems with the eruption or shedding of teeth? .....   | 19. <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has the child had any orthodontic treatment? .....   | 20. <input type="checkbox"/> | <input type="checkbox"/> |
| 21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water |                              |                          |
| 22. Does the child take fluoride supplements? .....  | 22. <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Is fluoride toothpaste used? .....   | 23. <input type="checkbox"/> | <input type="checkbox"/> |
| 24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____  | 24. <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does the child suck his/her thumb, fingers or pacifier? .....  | 25. <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Does child participate in active recreational activities? .....  | 26. <input type="checkbox"/> | <input type="checkbox"/> |

**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 take because of errors or omissions that I may have made in the completion of this form.

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_