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Child Health History Form

Patient Name: ______________________ ______________________ ___ ______________

Last First MI Preferred Name

Birth Date: ____________

Age: ____________

Parent/Guardian:

____

____

Is your child being treated by a physican at this time? ◯ Yes ◯ No

Has you child ever been in a hospital? ◯ Yes ◯ No

Has your child ever received general anesthesia? ◯ Yes ◯ No

Is your child allergic to anything? (medicine, food) ◯ Yes ◯ No

If yes, what?

____

____

Is your child taking any medicines at this time? ◯ Yes ◯ No

If yes, what?

____

____

Has your child ever been seen by a dentist before? ◯ Yes ◯ No

Has your child ever received flouride in any form? ◯ Yes ◯ No

If yes, what?

____

____

Does your child suck his/her thumb? ◯ Yes ◯ No

How often are child's teeth brushed a day? ____________

At what age did your child stop bottle/breat feeding? ____________

Organs and Systems

Please X if this child has ever had any treatment for any of the following:

- ☐ Blood -- Circulatory
- ☐ Bones
- ☐ Endocrine Glands
- ☐ Eyes, Ears, Nose, Throat
- ☐ Gastrointestinal
- ☐ Kidney -- Bladder
- ☐ Heart
- ☐ Liver Muscles Nervous Stystem
- ☐ Skin
- ☐ Tonsil/Adenoids
- ☐ This child has NOT had any treatment for the above.

Illnesses

Please X if this child has ever been diagnosed as having any of the following conditions.

☐ Anemia	☐ Allergy	☐ Arthritis	☐ Asthma	☐ Autism	☐ Brain Injury
☐ Cancer	☐ Cerebral Palsy	☐ Chicken Pox	☐ Cleft Lip/Palate	☐ Convulsions/Seizures	☐ Diabetes
☐ Diphtheria	☐ Emotional Disturbance	☐ Epilepsy	☐ Eye Problems	☐ Excessive Bleeding	☐ Fainting
☐ Hearing Loss	☐ Heart Disease	☐ Hemophilia	☐ Hepatitis: Type _____	☐ Jaundice	☐ Leukemia
☐ Measles	☐ Mental Rertardation	☐ Mumps	☐ Nutritional Deficiency	☐ Orthopedic Problems	☐ Pneumonia
☐ Polio	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Scoliosis	☐ Sickle Cell Anemia	☐ Spina Bifida
☐ Syndrome ______	☐ Tetanus	☐ Whooping Cough	☐ Other _________		

Is there anything else you think we should know about your child?

____

____

____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

PLEASE SIGN BELOW IF THIS IS A PRINTABLE COPY.

Signature ____ **Date** ____________

Response Date: ___________