Willow FAMILY DENTISTRY

Child Health History

Child Health/Dental History Form

First Name: _____ Middle Name: _____ Last Name: _____ Preferred Name: _____ Birth Date: _____

Parent's/Guardian's Name: _____ Relationship to Patient: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____ Gender: _____

Child's Medical History

Problems

- ☐ (TMJ) pain/jaw discomfort
- ☐ ADD / ADHD
- ☐ ADHD
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Anxiety/Nervousness
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cardiomyopathy (Heart Muscle Disease)
- ☐ Celiac disease
- ☐ Chemotherapy
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Congenital Heart Disease (CHD)
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Frequent Headaches
- ☐ Gag Reflux
- ☐ Heart Arrhythmias
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart transplant
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone imbalance or deficiency
- ☐ Infective endocarditis
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Nursing
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other
- ☐ Pneumonia
- ☐ Pregnant/planning
- ☐ PREMEDICATION NEEDED
- ☐ Radiation therapy?
- ☐ Rheumatoid arthritis
- ☐ Sensory Disorder
- ☐ Sexually transmitted disease
- ☐ Sickle Cell Disease
- ☐ Sjögren's syndrome
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke

Please list any other medical problems not listed above:

_____

Is your child taking any prescription and/or over the counter medications or vitamin supplements at this time?

Medication Name: _____ Comments/Dosage: _____

Is your child allergic to any of the following?

- ☐ Amoxicillan
- ☐ Cashews
- ☐ Eggs
- ☐ Flouride
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Milk
- ☐ Nuts
- ☐ Other
- ☐ Peanuts
- ☐ Penicillin or other antibiotics
- ☐ Pollen Dust
- ☐ Seasonal
- ☐ Soy
- ☐ Tree Nuts

How would you describe your child's eating habits?

_____

Has your child ever had a serious illness?

○ Yes
○ No

If yes, when: _____

Please explain:

Does your child use fluoride toothpaste?

○ Yes
○ No

	Yes	No
Has your child ever received a general anesthetic?	○	○
Does your child have any inher ited problems?	○	○
Does your child have any spee ch difficulties?	○	○

Has your child ever had a blood transfusion?	○	○
Is your child physically, mentally, or emotionally impaired?	○	○
Does your child experience excessive bleeding when cut?	○	○
Is your child currently being treated for any illnesses?	○	○

How many times does your child brush their teeth per day?

When are your child's teeth brushed?

Does your child suck their thumb, fingers or pacifier?

○ Yes

○ No

At what age did your child stop bottle feeding?

At what age did your child stop breast feeding?

Does your child participate in any active recreational activities?

NOTE: Both the 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.

Parent's/Guardian's Signature:

Sign