HEALTH HISTORY FORM

DIXON PEDIATRIC DENTAL GROUP

PERSONAL

Date _____

Child's Full Name _____ Nickname _____ Gender ____ Age ____

Birth date _____ Place of Birth _____ Is your child adopted? Y N If yes, does your child know Y N

What is your child most interested in? _____

Siblings, genders, names and ages? _____

Child's pediatrician physician _____ Phone# _____ Fax# _____

Family Dentist _____ Child attends what school _____

MEDICAL

Has your child had any of the following medical problems? Circle Yes or No.

Asthma or lung problems	Y N	Blood Transfusion	Y N	Cancer	Y N
Convulsion or epilepsy	Y N	Developmental delay	Y N	Diabetes	Y N
Trauma to mouth or face	Y N	Learning disabilities	Y N	Ear infections	Y N
Handicaps or disabilities	Y N	Rheumatic Fever	Y N	Heart murmur	Y N
Hemophilia or abnormal bleeding	Y N	Tuberculosis (TB)	Y N	HIV+/AIDS	Y N
Heart defect (congenital)	Y N	Cerebral Palsy	Y N	Allergies to latex	Y N
Hospital stays or operations	Y N	Hepatitis	Y N	Allergies to drugs/foods	Y N
Attention Deficit Disorder	Y N	High fevers	Y N	Please list _____	

Other medical problems: _____

Please discuss problems further, if necessary use back page:_____

_____

Is your child taking any supplemental fluoride? Y N If yes, how? Tables, drops, water, vitamins(please circle)

Is your child currently taking any medications? Y N If yes, What kind? _____

Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? (circle one)

Does your child snore Y N

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y N Please list _____

_____

HABITS

Does your child have any of the following habits?

Thumb or finger sucking	Y N	Pacifier use	Y N	Nail biting	Y N
Lip sucking or biting	Y N	Biting hard objects	Y N	Tooth grinding	Y N
Did your child use a bottle?	Y N				
Does your child currently use a bottle?	Y N				
Is the bottle used at night?	Y N				
Does your child currently nurse	Y N				

If yes, when did he/she stop? _____

If yes, how often during the day? _____

What do you put in the bottle? _____

FAMILY DENTAL HISTORY (circle appropriate parent, if yes)

Has Mother or Father had a lot of decay?

Has Mother or Father had orthodontic care?

Does Mother or Father have periodontal disease?

Does Mother or Father have TMJ problems?

Has your child seen a pediatric dentist before? Y N

If yes, the approximate month and year of last visit: _____ Where? _____

Has your child had any unfavorable experiences in a dental or medical office? Y N

If yes, please explain: _____

Does your child have any dental problems presently? Y N

If yes, please explain: _____

How often does your child brush his/her teeth per day _____ Do you help? Y N

How often does your child floss? _____ Do you floss your child's teeth? Y N

How do you think your child will act toward the dentist? _____

Purpose of today's dental visit? _____

Guardian's initials _____ Date: _____ Examining Doctor's Initials _____ Date: _____