CHILDS HEALTH HISTORY UPDATE

IT IS IMPORTANT FOR US TO MAINTAIN ACCURATE RECORDS. PLEASE KEEP US UP-TO-DATE BY COMPLETING THE FOLLOWING.
If you have any questions, we will be glad to assist you.

GENERAL INFORMATION			
CHILD'S NAME		PREFERRED NAME	
DATE OF BIRTH		DESCRIBE CHILD'S TEMPERAMENT	
☐ MALE ☐ FEMALE	AGE:	GRADE	SCHOOL
NAME OF PARENT/GUARDIAN FILLING OUT THIS FORM			
PARENT'S PHONE NUMBER		SECONDARY PHONE NUMBER	
PARENT'S EMAIL			

DENTAL HISTORY			
HOW MANY TIMES A DAY DOES YOUR CHILD DO THE FOLLOWING?			
BRUSH?	FLOSS?	FLUORIDE RINSE?	FLUORIDE SUPPLEMENT?
HOW OFTEN DO THEY SNACK?		WHATS THEIR MOST COMMON SNACK?	
DRINK WATER FROM TAP? ☐ YES ☐ NO		WHAT IS THEIR MOST COMMON DRINK?	
CURRENTLY NURSING FEEDING OR BOTTLE FEEDING? ☐ YES ☐ NO IF SO, HOW OFTEN?			

MEDICAL HISTORY					
HAS OR DOES YOUR CHILD HAVE ANY OF THE FOLLOWING DISEASES OR CONDITIONS?					
AUTISM	☐ YES ☐ NO	HEARING/SPEECH IMPAIRMENT	☐ YES ☐ NO	HEART VALVE REPLACEMENT	☐ YES ☐ NO
EPILEPSY/FAINTING/ SEIZURES	☐ YES ☐ NO	HEART DISEASE/ MURMURS	☐ YES ☐ NO	HEMOPHILIA/BLEEDING ISSUES	☐ YES ☐ NO
ASTHMA	☐ YES ☐ NO	Last Used/attack: Treatment:			
ALLERGIES	☐ YES ☐ NO	☐ Seasonal ☐ Metal ☐ Aspirin ☐ Sulfa ☐ Latex ☐ Local Anesthetic ☐ Penicillin/Amoxicillin ☐ Foods: _____ ☐ Other: _____			
SURGERIES/ HOSPITALIZATIONS	☐ YES ☐ NO	Please include type & dates			
MEDICATIONS	☐ YES ☐ NO	Please include medication & doses			
FEMALE PATIENTS	Could you be pregnant? ☐ YES ☐ NO				
IF YOU MARKED YES TO ANY OF THE ABOVE, PLEASE INCLUDE ADDITIONAL INFORMATION:					

Signature of Parent/Guardian_____ Date _____