Child Health History Form (Confidential)

Child's Name_____ Date of Birth_____ Age_____Date_____
Address_____Telephone: ( )_____
Social Security Number_____ Sex_____ Height_____Weight_____lbs.
Relationship to the patient (i.e. mother, father)_____
Physician's name (Medical Doctor)_____Telephone: ( )_____

Please circle the appropriate answer

1. Does your child have a health problem?.....YES NO
2. Was your child a patient in a hospital?..... YES NO
3. Date of last physical exam: _____
4. Is your child now under medical care?.....YES NO
5. Is your child taking medication now?.....YES NO
   a. If so, for what? _____
6. Has your child ever had a serious illness or operation? YES NO
7. If so, explain: _____
8. Does your child have (or ever had) any of the following disease?
   a. Rheumatic fever or rheumatic heart disease..... YES NO
   b. Congenital heart disease..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... YES NO
   d. Allergy? Food ❑ Medicine ❑ Other ❑ ..... YES NO
   e. Asthma ❑ Hay Fever ❑..... YES NO
   f. Hives or a skin rash..... YES NO
   g. Fainting spells or seizures..... YES NO
   h. Hepatitis, jaundice or liver disease..... YES NO
   i. Diabetes..... YES NO
   j. Inflammatory rheumatism (painful or swollen joints)..... YES NO
   k. Arthritis..... YES NO
   l. Stomach ulcers..... YES NO
   m. Kidney trouble..... YES NO
   n. Tuberculosis (TB)..... YES NO
   o. Persistent cough or cough up blood..... YES NO
   p. Venereal disease (i.e syphilis, gonorrhea)..... YES NO
   q. Epilepsy..... YES NO
   r. Sickle Cell disease..... YES NO
   s. Thyroid disease..... YES NO
   t. AIDS or HIV..... YES NO
   u. Emphysema..... YES NO
   v. Psychiatric treatment..... YES NO
   w. Cleft lip/palate..... YES NO
   x. Cerebral palsy..... YES NO
   y. Mental retardation..... YES NO
   z. Hearing disability..... YES NO
   aa. Developmental disability..... YES NO
   If yes, explain: _____
   bb. Was your child premature?..... YES NO
   If yes, how many weeks
   cc. Other: _____
9. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents?..... YES NO
10. Does he/she bruise easily?..... YES NO
11. Has he/she ever required a blood transfusion?..... YES NO
12. Does he/she have any blood disorders such as anemia, etc?..... YES NO
13. Has he/she ever had surgery, x-ray or chemotherapy for a tumor, growth, or other condition?..... YES NO
14. Does your child have a disability that prevents treatment in a dental office?..... YES NO
15. Is he/she taking any of the following?
   a. Antibiotics or sulfa drugs..... YES NO
   b. Anticoagulants (blood thinners)..... YES NO
   c. Medicine for high blood pressure..... YES NO
   d. Cortisone or steroids..... YES NO
   e. Tranquilizers..... YES NO
   f. Aspirin..... YES NO
   g. Dilantin or other anticonvulsant..... YES NO
   h. Insulin, tolbutamide, Orinase, or similar drug..... YES NO
16. Is he/she allergic to, or has he/she ever reacted adversely to any of the following?
   a. Local anesthetics..... YES NO
   b. Penicillin or other antibiotics..... YES NO
   c. Sulfa Drugs..... YES NO
   d. Barbiturates, sedatives, or sleeping pills..... YES NO
   e. Aspirin..... YES NO
   f. Any other? _____
17. To the best of your knowledge, has any blood relative had a bad reaction to any anesthetic?..... YES NO

ADOLESCENT WOMEN:

18. Are you pregnant now, or think you may be?..... YES NO
19. Do you anticipate becoming pregnant?..... YES NO
20. Are you taking the Pill?..... YES NO
21. When was your last menstrual period?

Please list all of the prescription and over-the-counter medications that your child takes below:

Drug	Dose	Reason

I understand that withholding any information about my child's health could seriously jeopardize his/her safety. Therefore, I have reviewed this health history carefully and have answered all questions truthfully and to the best of my knowledge.

Signature of Patient (or Guardian)_____ Date _____

Reviewed by: Kathryn M. Le, DDS _____ Date _____