HEALTH HISTORY QUESTIONNAIRE

Has your child had previous Anesthesia/Sedation or Surgery? YES NO

If Yes, please list:_____

Complications, please list: _____

Does your child take any medications? YES NO

If Yes, please list:_____

Does your child have any allergies to any medications, food, or nickel? YES NO

If Yes, please list:_____

Does your child have a reaction to local anesthetics (i.e. Novocain) or antibiotics? YES NO

If Yes, please list:_____

Please answer the following questions to the best of your ability:

Has your child ever had any of the following (please circle all that apply):

Respiratory: Asthma Sleep Apnea Snoring Seasonal Allergies Recent Cold/Flu Frequent Ear/Tonsil Infections Sinus Tuberculosis Other:_____

Cardiovascular: Murmur Congenital Defect Rheumatic Fever High Blood Pressure Heart Attack Angioplasty/Stents Chest Pain Abnormal Heart Rhythm Other:_____

Liver/Gastrointestinal: Hepatitis Heartburn Ulcers Hernia Bowel/Colon Other:_____

Neurological/Musculoskeletal: Seizures Developmental Disability ADD/ADHD Migraines/Headaches Autism Anxiety Depression Stroke Hearing Impairment Numbness/Tingling Arthritis Back Pain Learning Disability Speech Other:_____

Renal/Endocrine: Diabetes Thyroid Kidney Stones Recent Weight Loss/Gain Other:_____

Hematologic: Cancer/Chemotherapy HIV Bleeding Problems Low Blood Count Other:_____

Is your child under the care of a physician for any chronic medical problems? YES NO

Please list the name of the supervising Physician responsible for your child's care:

Physician Name:_____Physician Phone:_____

Physician Address:_____

DENTAL HISTORY

Last visit to a dentist:_____ _____

(Approximate Date) (Dentist Name)

What concerns regarding your child's teeth prompted this visit?

_____I desire comprehensive dental care for my child

_____I have specific dental concerns. My concerns are:_____

_____My child has complained about dental problems

_____My child suffered an injury to the head/mouth/teeth, if so please explain:_____

Has your child had any history of the following habits?

Thumb-sucking Finger-sucking Lip Biting Nail Biting Pacifier

Are any of these habits currently active? YES NO

Child attitude toward dentistry:_____