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			
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?		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:					

Print Name: _____

Signature of Parent/Guardian_____ Date _____