Child Health History Conte & Green, DDS

Name_____ Date_____

Primary reason for this appointment: ☐Examination ☐Emergency ☐Consultation

Dental History

1. Does the child have a specific dental problem? ☐yes ☐no. If yes, please describe:
_____

2. Does the child have dental examinations on a routine basis? ☐yes ☐no
If yes, when was your last visit?_____
3. Has the child's past experiences in the dental office been positive? ☐yes ☐no
If no, please describe? _____

Medical History

1. Is the child currently under the care of a physician? ☐yes ☐no
If yes, why? _____
2. Physician's name? _____ Phone # _____
3. Has the child ever been hospitalized or had a major operation? ☐yes ☐no
If yes, please describe: _____
4. Has the child ever had a serious injury to your head or neck? ☐yes ☐no
If yes, please describe: _____
5. Is the child taking any medications, pills or drugs? ☐yes ☐no
If yes, what? _____
6. Is the child allergic to any medications or substances? ☐yes ☐no
If yes, what? _____

7. Has the child had any of the following? **Please write the word "yes" or "no" in the box to right:**

Heart trouble/disease		Hemophilia		Kidney Disease	
Heart Murmur		Leukemia		Thyroid Disease	
Irregular Heart Beat		Blood Transfusion		Arthritis	
Congenital Heart Disorder		Breathing Problem		AIDS/HIV +	
Mitral Valve Prolapse		Sinus Trouble		Drug Addiction	
Rheumatic Fever		Asthma		Herpes	
Artificial Heart Valve		Tuberculosis		Epilepsy/Seizures	
Blood Disease		Cancer		Fainting/Dizziness	
Bruise Easily		Radiation Treatment		Tumors/Growths	
Anemia		Chemotherapy		Psychiatric Care	
Excessive Bleeding		Stomach problems		Hives or Rash	
Diabetes		Ulcers		Hepatitis	
Sickle Cell Disease		Hypoglycemia			

Has the child ever had any other serious illness or condition not mentioned above? ☐yes ☐no
If yes, what? _____

X _____ Date _____
Parent's Signature

Reviewed By Doctor_____ Date_____