



Pediatric Health History

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Whom may we thank for referring this patient? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ With whom \_\_\_\_\_

Explain briefly why you brought your child for dental care: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Because your child is a minor, your signature as a parent or guardian must be obtained to authorize any necessary dental service. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental service.

Signature \_\_\_\_\_

Family physician or pediatrician \_\_\_\_\_

Date of last medical examination \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_

Relative's Home Phone# \_\_\_\_\_ Relatives' Work Number \_\_\_\_\_

Has your child had any of the following? Please indicate with a checkmark:

- Allergies to Anesthesia
- Allergies to Medicines / Drugs
- Allergies to \_\_\_\_\_
- Anemia
- Asthma
- Autism
- Bleeding Disorders
- Contagious Disease
- Diabetes
- Epilepsy
- Heart Problems
- Hepatitis
- HIV Virus
- Kidney / Liver
- Oral Herpes
- Malignancies
- Measles
- Mumps
- Nervousness
- Psychiatric Care
- Rheumatic Fever
- Scarlett Fever
- Sinus Problems
- Stroke
- Typhoid Fever
- Tonsillitis
- Tuberculosis

Is your home supplied by well water? ..... Yes  No

Does your child have health problems that require the active care of a physician?..... Yes  No

Is your child presently taking any medications?..... Yes  No

Has your child ever been hospitalized?..... Yes  No

Reason \_\_\_\_\_

Do you consider your child to be progressing normally?..... Yes  No

If not, explain: \_\_\_\_\_

OFFICE USE ONLY			MEDICAL HISTORY UPDATE					
Date	No Change	Change	Date	No Change	Change	Date	No Change	Change
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

