



Healthy Smiles Start Here

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:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies to Anesthesia | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Kidney / Liver | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies to Medicines / Drugs | <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Oral Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergies to _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Sinus Problems |
| _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> HIV Virus | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> 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
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

