Patient Health History

Dental History

- Main purpose of today's visit: _____
- How long since your last dental exam: _____
- Is the child currently in pain? YES NO
- Is your child nervous about having dental work done? YES NO

Oral Hygiene

- Does your child brush their teeth daily? YES NO
- Do they floss daily? YES NO
- What type of toothbrush do they use? Soft Medium Hard

Medical History

Please circle all that apply:

Anemia	Cerebral Palsy	Epilepsy	Hepatitis	Liver
Arthritis	Chicken Pox	Fainting	HIV/AIDS	Measles
Asthma	Chronic Sinusitis	Growth Problems	Mumps	ADD/ADHD
Bleeding Disorders	Diabetes	Hearing	Kidney	Autism
Cancer	Heart	Latex Allergy	Seizures	
Sickle Cell	Thyroid	Tuberculosis	Tobacco/Drug Use	
Pregnancy (teens)	Psychiatric Treatment	Depression		

If there are any other medical issues, please list: _____

Is your child currently taking any medications?

_____

Does your child have a food allergy or allergy to any medications such as penicillin, amoxicillin?

_____

_____

Parent Signature: _____ Date: _____