Health History

Date: ______________ Child's Name: ____ Date of Birth: ________________

Nickname: ____

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child had any of the following:

Condition	Yes	No	Condition	Yes	No
Asthma	❑ Yes	❑ No	Handicaps/Disabilities	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Learning Disabilities	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Intellectually Disabled	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No	Behavior Problems	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Abnormal Bleeding	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Blood Transfusions	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Allergies to Drugs	❑ Yes	❑ No	Congenital Heart Defect	❑ Yes	❑ No
Allergies to Foods	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Shunts/Prostheses	❑ Yes	❑ No	Convulsions/Epilepsy	❑ Yes	❑ No
Pregnancy	❑ Yes	❑ No	Cerebral Palsy	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No

Please explain any medical problems your child has: ____

____

Please list any medications your child is taking: ____

____

Child's Physician: ____ Phone: ______________________

Immunizations up-to-date: ❑ Yes ❑ No

Child's Habits

How often does your child brush? ______________________ Floss? ____

Date of last dental visit? ____________________________ Previous Dentist: ____

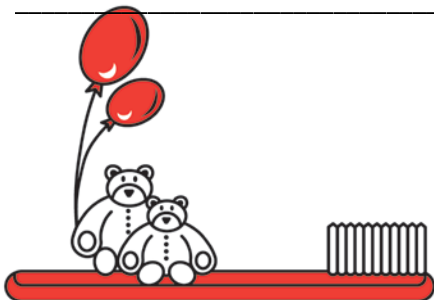
Has your child had difficulty with previous dental visits? ____

Does your child:

Habit	Yes	No	Habit	Yes	No
Suck thumb/finger	❑ Yes	❑ No	Chew hard objects	❑ Yes	❑ No
Bite/chew nails	❑ Yes	❑ No	Drink from a bottle	❑ Yes	❑ No
Grind teeth	❑ Yes	❑ No	If so, in bed?	❑ Yes	❑ No
Clench jaw	❑ Yes	❑ No	If not, age off bottle:	______________	
Suck/bite lips	❑ Yes	❑ No	Have fluoridated waters	❑ Yes	❑ No
Use pacifier	❑ Yes	❑ No	Take fluoride supplements	❑ Yes	❑ No

Please list any specific concerns you may have about your child's teeth: ____

____



Margaret Madonian, DDS

How did you hear about our office? ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Legal Guardian Signature: ____

Date: ________________