CENTENNIAL CHILDREN'S DENTAL CENTER

www.ccdcsmiles.com

# HEALTH HISTORY FORM

## CHILD'S INFORMATION

Child's Name _____

Date of Birth _____ Gender _____ Age _____

## DENTAL HISTORY

Has your child ever been to the dentist before? ☐ YES ☐ NO

***(If YES answer the following questions, If NO skip to Question 6)***

1. When was his/her last visit to the dentist? _____

   Were x-rays taken at his/her last visit? ☐ YES ☐ NO

2. Has your child had any cavities in the past? ☐ YES ☐ NO

3. Has he/she had any problems with dental treatment in the past? ☐ YES ☐ NO

4. Has your child had any teeth removed by extraction in the past? ☐ YES ☐ NO

   For what purpose? _____

   Was a space maintaining appliance placed? ☐ YES ☐ NO

5. Has he/she ever had sealants placed by a dentist? ☐ YES ☐ NO

6. How often does your child eat sweets? (Candy, Soda, Cookies, etc) ☐ Rarely ☐ Once a day ☐ Frequently

   How many times a day does your child brush his/her teeth? _____

   When does your child brush his/her teeth?

   ☐ Morning ☐ After eating any food ☐ After meals ☐ Before going to bed

7. Does your child have bad breath? ☐ YES ☐ NO

8. Is your child a mouth breather? ☐ YES ☐ NO

9. Has your child ever had cold sores? ☐ YES ☐ NO

10. Does your child suck his/her thumb or fingers? ☐ YES ☐ NO

11. Has he/she ever experienced any injuries to the teeth? ☐ YES ☐ NO If so describe _____

12. Has anyone in the family, including parents received orthodontic treatment? ☐ YES ☐ NO

13. Has your child ever had local anesthetic? ☐ YES ☐ NO

    If yes how did he/she do? _____

14. Do you or your child have any concerns about his/her teeth? ☐ YES ☐ NO

    If yes please explain _____

# HEALTH HISTORY FORM

## CHILD'S INFORMATION

Child's Name _____ Date of Birth _____

## MEDICAL HISTORY

1. Does your child have any health problems we should be aware of?..... ☐ YES ☐ NO
   If yes please explain _____
2. Is he/she under the care of a physician now? ..... ☐ YES ☐ NO
   If yes, explain _____
   Physician name _____
   Phone number _____
3. Is he/she currently taking any medications?..... ☐ YES ☐ NO
   Please list all medications _____
4. Does your child have any medication allergies? ..... ☐ YES ☐ NO
   Please list _____
5. Has your child had any serious illness? ..... ☐ YES ☐ NO
   If so, please explain: When _____ What _____

**Please check all that apply and add relevant explanations:**

| | | | |
|---|---|---|---|
| ☐ Penicillin Allergy | ☐ Autism | ☐ Cancer | ☐ History of Fainting |
| ☐ Antibiotic Allergy | ☐ Cerebral Palsy | ☐ Diabetes | ☐ History of Dizziness |
| ☐ Sulfa Allergy | ☐ Congenital Birth Defect | ☐ Epilepsy | ☐ History of Seizures |
| ☐ Latex Allergy | ☐ Developmental Delay | ☐ Heart Murmur | ☐ AIDS or HIV Positive |
| ☐ Allergy to Metal | ☐ Down Syndrome | ☐ Hearing Loss | ☐ Hepatitis A |
| ☐ Gluten Allergy | ☐ Mental Illness | ☐ Liver Problems | ☐ Hepatitis B |
| ☐ Nut Allergy | ☐ Sensory Issues | ☐ Kidney Problems | ☐ Hepatitis C |
| ☐ Other Allergy | ☐ Speech Impairment | ☐ Obesity | ☐ Rheumatic Fever |
| ☐ ADD/ADHD | ☐ Asthma | ☐ Severe/Prolonged Bleeding | ☐ Other Disease |

Explanations: _____

_____

**The information I have provided above is complete and accurate.**

_____ _____

Responsible Party Date