COLORADO CHILDREN'S DENTAL CENTER

www.ccdcsmiles.com

HEALTH HISTORY FORM

CHILD'S INFORMATION

Child's Name: _____

Date of Birth: _____ Gender: _____ Age: _____

DENTAL HISTORY

(please circle one)

Has your child been to the dentist before? Y N **(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? ..... Y N
2. Has your child had any cavities in the past? ..... Y N
3. Has he/she had any problems with treatment in the past? ..... Y N
4. Has your child ever had local anesthetic? ..... Y N
   If yes, how did he/she do? _____
5. Has he/she ever had sealants placed by a dentist..... Y N

6. How often are your child's teeth brushed? _____
   Does mom / dad help? _____
7. Do your currently use Fluoride toothpaste? _____
8. Are there any habits present? (such as pacifier, thumb sucking, finger sucking) _____
9. Does your child use a bottle or sippy cup? _____
10. How often does your child have milk? _____ Juice, Gatorade, Soda? _____
11. Do you or your child have any concerns about his/her teeth?
    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