



# Introduction & Child Health History Sheet

IN ORDER THAT WE MAY THOROUGHLY EVALUATE YOUR DENTAL PROBLEM, YOUR KINDNESS IN FURNISHING THE FOLLOWING INFORMATION WILL BE APPRECIATED. ALL ANSWERS WILL BE HELD IN STRICT CONFIDENCE AND USED IN THE PREPARATION OF YOUR CLINICAL TREATMENT CHART.

1. CHILD'S NAME		2. BIRTHDATE:				ADDRESS	CITY	STATE	ZIP
LAST	FIRST	M.	MO.	DAY	YEAR				
CHILD'S SS #						PARENT / GUARDIAN EMAIL			
HOME PHONE:						CELL PHONE:			
SCHOOL:						WORK PHONE (PT):			
						REFERRED BY:			
PARENT / GUARDIAN			RELATIONSH P			PREVIOUS DENTIST		LAST VISIT DATE	
CHILD'S PHYSICIANS NAME			ADDRESS			PHONE			

<p>Is child receiving treatment from a physician at the present time? YES NO If so, for what?</p> <p>Is this the child's first visit to the dentist? YES NO</p> <p>Has child ever had severe &amp; prolonged bleeding after cuts or tooth extractions? YES NO</p> <p>Does your child bruise easily? YES NO</p> <p>Has child ever been given local anesthetic (novocaine)? YES NO</p> <p>Were there any unfavorable reactions to this? YES NO</p> <p>Has child's tonsils been removed? YES NO If yes, at what age?</p> <p>Please indicate below which of the following diseases your child has had:</p> <table style="width:100%; border: none;"> <tr> <td>Measles</td> <td>Liver Disease</td> </tr> <tr> <td>Mumps</td> <td>Asthma</td> </tr> <tr> <td>Chicken Pox</td> <td>Kidney Disease</td> </tr> <tr> <td>Scarlet Fever</td> <td>Whooping Cough</td> </tr> <tr> <td>Heart Disease</td> <td>Anemia</td> </tr> <tr> <td>Rheumatic Fever</td> <td>Cerebral or Mental Imbalance</td> </tr> <tr> <td>Diabetes</td> <td></td> </tr> <tr> <td>Epilepsy (seizures)</td> <td>Other</td> </tr> <tr> <td>Polio</td> <td></td> </tr> </table> <p>Has child ever had surgery on X-ray treatment for a tumor, growth or other condition in your mouth or on your lips, or other areas of the body? YES NO</p>	Measles	Liver Disease	Mumps	Asthma	Chicken Pox	Kidney Disease	Scarlet Fever	Whooping Cough	Heart Disease	Anemia	Rheumatic Fever	Cerebral or Mental Imbalance	Diabetes		Epilepsy (seizures)	Other	Polio		<p>Does child have a prosthetic (artificial) heart valve, heart murmur or Mirtal Valve Prolapse? YES NO</p> <p>Is child allergic (sensitive) to any food or drugs such as aspirin, penicillin or novocaine? YES NO If so, what?</p> <p>Is child taking any medicines at the present time? YES NO If so, what?</p> <p>Does your child take vitamin supplements with fluoride? YES NO</p> <p>Has child ever been given general anesthetic (been put to sleep), either for oral surgery or any other type of surgery? YES NO</p> <p>Do you object to child having to Bite Wing X-rays once a year? YES NO</p> <p>Please indicate below which of the following habits your child has, or had, and at about what age the habit ended:</p> <table style="width:100%; border: none;"> <tr> <td>Thumbsucking</td> <td>Stopped at what age:</td> </tr> <tr> <td>Fingersucking</td> <td>Stopped at what age:</td> </tr> <tr> <td>Blanket Sucking</td> <td>Stopped at what age:</td> </tr> <tr> <td>Lip Biting</td> <td>Stopped at what age:</td> </tr> <tr> <td>Nail Biting</td> <td>Stopped at what age:</td> </tr> <tr> <td>Mouth Breathing</td> <td>Stopped at what age:</td> </tr> <tr> <td>Other oral habits:</td> <td></td> </tr> </table> <p>Have you any OTHER reason to think that your child is not now in good health? YES NO If so, what?</p>	Thumbsucking	Stopped at what age:	Fingersucking	Stopped at what age:	Blanket Sucking	Stopped at what age:	Lip Biting	Stopped at what age:	Nail Biting	Stopped at what age:	Mouth Breathing	Stopped at what age:	Other oral habits:	
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UPDATES:

Date	Initials	Date	Initials	Date	Initials	Parent / Guardian Signature	Date
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