CHILDREN'S CORNER
PEDIATRIC DENTISTRY

PATIENT HEALTH HISTORY

(Your responses are for our records only & are considered strictly confidential)

DEMOGRAPHIC INFORMATION:

Child's Name: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Child's Physician: _____ Ph: _____ Orthodontist: _____ Ph: _____

MEDICAL HISTORY:

Is your child presently under a physician's care, or has been during the past 5 years including hospitalizations and ER visits? Yes No

If yes, please explain. _____

Yes	No		Yes	No		Yes	No	
O	O	Rheumatic fever?	O	O	Mentally challenged?	O	O	Do wounds or cuts heal slowly?
O	O	Rheumatic heart disease?	O	O	Kidney disorders?	O	O	Scarlet fever?
O	O	Heart murmur/Heart trouble?	O	O	Asthma?	O	O	Tuberculosis?
O	O	Cogenital heart defect	O	O	Hearing/Speech Impairment?	O	O	Fainting or dizziness?
O	O	Bleeding problems?	O	O	Developmental delay?	O	O	Thyroid or gland problems?
O	O	Sickle cell trait?	O	O	Diabetes?	O	O	Liver disease?
O	O	AIDS/HIV?	O	O	Hepatitis?	O	O	Treatment for cancer?
O	O	ARC (AIDS related complex)?	O	O	Leukemia?	O	O	Frequent colds?
O	O	Anemia?	O	O	Epilepsy (convulsion or fits)?	O	O	Birth defects/malformations?
O	O	High blood pressure?	O	O	Bruise or have frequent nose bleeds?	O	O	Immunizations up to date?

MEDICATIONS:

Please list any and all medications that your child is presently taking (antibiotics, pain medication, heart medicine, vitamins):

_____

ALLERGIES:

Yes	No		Reaction:	Yes	No		Reaction:
O	O	Local anesthetics (lidocaine)	_____	O	O	Codeine/narcotics	_____
O	O	General anesthetics	_____	O	O	Penicillin, Sulfa Drugs	_____
O	O	Aspirin	_____	O	O	Latex	_____
O	O	Soy, nuts or eggs	_____	O	O	Others (please list):	_____

DENTAL HISTORY:

Has your child had any accidents involving the teeth or jaws? Yes No Date: _____

If yes, please explain. _____

Does your child have or do any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
O	O	Thumb or finger sucking	O	O	Gritting or grinding teeth	O	O	Tongue thrusting	O	O	Mouth breathing
O	O	Missing teeth	O	O	Extra teeth	O	O	Impacted teeth	O	O	Tumors or cysts of jaws
O	O	Deformed or discolored teeth									

Please check all words which seem best to describe your child or adolescent:

O Calm	O Healthy	O Friendly	O Cooperative	O Spoiled	O Talkative	O Active	O Compulsive
O Shy	O High strung	O Moody	O Sickly	O Suspicious	O Temper	O Fearful	O Defiant

SURGICAL HISTORY:

List any previous surgeries or procedures that your child has had: _____

Nausea & Vomiting? Yes No Malignant Hyperthermia? Yes No Family History of Anesthesia Complications? Yes No

Prolonged Bleeding? Yes No Blood Transfusion? Yes No If yes, please specify: _____

HEALTH INFORMATION CERTIFICATION:

I hereby certify that the above information regarding the medical history of _____ (of the above stated patient) is complete, true, and correct and may be relied upon for all purposes by Children's Corner Pediatric Dentistry, their assistants, colleagues, staff employees, and any other persons treating or assisting in the treatment of the patient.

SIGNATURE: _____ **DATE:** _____ **RELATIONSHIP TO THE PATIENT:** _____

SURGEON SIGNATURE: _____ **DATE:** _____

UPDATED ON: **PATIENT INITIAL:** **REVIEWED BY:**

_____ _____ _____

Patient Label