Blasek Family Dentistry

Child Health Dental History Form

First Name: Middle Initial: Last Name:

Date of Birth: Gender: MALE FEMALE

Parent/ Guardian Name: Parent/Guardian Phone Number:

Relationship to patient:

Address:

Has the child had any history of, or conditions related to, any of the following?:

- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Chicken Pox
- ☐ Epilepsy
- ☐ Heart
- ☐ Kidney
- ☐ Mononucleosis
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Bones/ Joints
- ☐ Chronic Sinusitis
- ☐ Fainting
- ☐ Hepatitis
- ☐ Latex Allergy
- ☐ Mumps
- ☐ Sickle Cell
- ☐ Venereal Disease
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes (Type I/ Type II)
- ☐ Growth Problems
- ☐ HIV +/AIDS
- ☐
- ☐ Pregnancy (teens)
- ☐ Thyroid
- ☐ Other:
- ☐ Bladder
- ☐ Cerebral Palsy
- ☐ Ear Aches
- ☐ Hearing
- ☐ Immunizations
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Tobacco/ Drug User

Please list the name and phone number of the child's physician:

Name of Physician: Phone:

Child's History

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list
2. Is the child allergic to any medications, i.e penicillin, antibiotics or other drugs? ☐ YES ☐ NO – If yes, please list
3. Is the child allergic to anything else, such as certain foods? ☐ YES ☐ NO – If yes, please list
4. Has the child ever had a serious illness? ☐ YES ☐ NO
5. Has the child ever been hospitalized? ☐ YES ☐ NO
6. Does the child have a history of any other illness? ☐ YES ☐ NO
7. Has the child ever received a general anesthetic? ☐ YES ☐ NO
8. Does the child have any speech difficulties? ☐ YES ☐ NO
9. Is the child physically, mentally or emotionally impaired? ☐ YES ☐ NO
10. Is the child currently being treated for illness? ☐ YES ☐ NO
11. Is this the child's first visit to a dentist? ☐ YES ☐ NO
12. If not the first visit, what was the date of their last dentist visit?
13. Has the child had any problem with dental treatment in the past? ☐ YES ☐ NO
14. Has the child ever had dental x-rays? ☐ YES ☐ NO
15. Has the child ever suffered any injuries to the mouth, head or teeth? ☐ YES ☐ NO
16. Has the child had any problems with the eruption or shedding of teeth? ☐ YES ☐ NO
17. Has your child had any orthodontic treatment? ☐ YES ☐ NO
18. Does the child take fluoride supplements? ☐ YES ☐ NO
19. How many times are the child's teeth brushed per day?
20. Does the child suck his/her thumb, fingers or pacifier? ☐ YES ☐ NO

Signature: ______________________________ **Date:** ______________