HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is child under care of physician now	☐	☐
Is child receiving any medication or drugs	☐	☐
Is there any excessive bleeding when cut	☐	☐
Has child ever been hospitalized	☐	☐
Has child ever had surgery	☐	☐
Is there any allergy to penicillin or other drugs	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	YES	NO
Does child have good physical coordination	☐	☐
Are there any emotional problems	☐	☐

Summary (for doctor's use) _____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

_____ ADD / ADHD	_____ Cleft Lip/Palate	_____ Heart Murmur	_____ Measles	_____ Thyroid
_____ Anemia	_____ Diabetes	_____ HIV / AIDS	_____ Mononucleosis	_____ Tuberculosis
_____ Asthma	_____ Epilepsy	_____ Kidney	_____ Mumps	_____ Venereal Disease
_____ Bladder	_____ Fainting	_____ Liver	_____ Rheumatic Fever	_____ Other
_____ Cerebral Palsy	_____ Fever Blisters	_____ Malignancies	_____ Seizures	
_____ Chicken Pox	_____ Hearing	_____ **Malignant Hyperthermia**	_____ Sickle Cell	
_____ Chronic Sinus	_____ Heart	_____ Mastoid	_____ Sleep Apnea	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

_____

_____

	YES	NO
May we request release of your child's medical records for our reference _____	☐	☐

Please be aware that the parent or guardian bringing the child to our office is legally responsible for payment of all charges regardless of who provides insurance coverage. We look forward to years of friendship as we work together to maintain your child's oral health.

I understand that I am financially responsible for this patient:

Signature _____ Date _____

Relation to Child _____