

HEALTH HISTORY
(for children under 15 years of age)

Patients Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____
Parent or Legal Guardian _____
Cell # _____ Work # _____
Childs Physician _____ Telephone _____
Name of School _____ Grade _____
Reason for todays visit _____
Referred By _____

CIRCLE "YES" OR "NO"

1. Has your child ever been to a dentist?----- YES NO
2. Has he/she had any problems with dental treatment?----- YES NO
3. Does your child have regular medical examinations?----- YES NO
4. Is your child presently in good heath?----- YES NO
5. Is your child presently under a physicians care?----- YES NO
6. Is your child presently taking medication?----- YES NO
7. HAS YOUR CHILD EVER HAD HISTORY OF ANY OF THE FOLLOWING:
 - a. Heart trouble, damaged heart valves, heart murmurs, mitral valve prolapse, rheumatic heart disease ----- YES NO
 - b. Artificial joints ----- YES NO
 - c. High blood pressure/Low blood pressure ----- YES NO
 - d. Rheumatic fever ----- YES NO
 - e. Bleeding disorders ----- YES NO
 - f. Diabetes ----- YES NO
 - g. Kidney or liver disease ----- YES NO
 - h. Tuberculosis ----- YES NO
 - i. Allergies ----- YES NO
 - j. Polio ----- YES NO
 - k. Whooping cough ----- YES NO
 - l. Scarlet fever ----- YES NO
 - m. Chicken pox, Measles, Mumps ----- YES NO
 - n. Latex Allergy ----- YES NO
 - o. Epilepsy (fainting spells or convulsions) ----- YES NO

- p. AIDS or HIV infection -----YES NO
- q. Cerebral palsy -----YES NO
- r. Mentally challenged -----YES NO
- s. Asthma -----YES NO
- t. Speech impediments -----YES NO
- u. Tumors -----YES NO
- 8. Has he/she ever had a reaction to any medication? -----YES NO
If yes which one(s) _____
- 9. Does your child have any special needs? -----YES NO
- 10. Has he/she had tonsils and adenoids removed? -----YES NO
- 11. Has he/she ever had bleeding gums? -----YES NO
- 12. Are your childs teeth sensitive to any of the following;
 - a. Cold, hot, sweets, chewing -----YES NO
- 13. Does your child have a history of the following:
 - a. Thumb/finger sucking -----YES NO
 - b. Tongue thrusting -----YES NO
 - c. Fingernail biting -----YES NO
 - d. Mouth breathing -----YES NO
 - e. Grinding teeth -----YES NO
- 14. Is your water fluoridated -----YES NO
- 15. Does he/she take fluoride tablets or drops? -----YES NO
- 16. Is there any other information you think we should know,
such as a disease, condition or problem? -----YES NO

GIRLS

- 17. Does your child menstruate? -----YES NO
- 18. Does your child have any problems with menstruation? -----YES NO

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set for the above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I hereby grant authority to Casanova & Imhoff, D.M.D., P.A. to administer any treatment, to administer such anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and the treatment of my childs case.

Signature _____ Date _____

Witness _____ Date _____

Doctor _____ Date _____