CHILD HEALTH HISTORY

Patient _____ Age _____ Birthdate _____

Address _____ Phone _____

School _____ Grade _____

Mother's name _____

Mother's workplace _____ Phone

Father's name _____

Father's workplace _____ Phone _____

Are parents Unmarried _____ or Married _____

Dentist _____ Physician _____

Referred By _____

Dental Insurance _____ SSN _____

	yes	no
Do you have any health problems?		
Has there been any change in the past year?		
Are you under the care of a physician?		
If so, what is the condition being treated? _____		
Are you allergic to aspirin or penicillin?		
Do you have any other allergies?		
If so, what? _____		
Are you pregnant?		
Are you taking any medications?		
If so, what? _____		
Do you have or have you had any of the following?		
-Rheumatic fever or rheumatic heart disease?		
-Congenital heart lesions or murmurs?		
-Cardiovascular disease? (high blood pressure, heart attack)		
-Asthma or hay fever?		
-Fainting spells or seizures?		
-Diabetes?		
-Hepatitis, jaundice or liver disease?		
-Arthritis or inflammatory rheumatism?		
-Kidney trouble?		
-Tuberculosis?		
-Blood disorders?		
Do you have any disease, condition, or problem not listed above that you think I should know about?		
If so, please explain _____		

_____ Parent Signature and Date

_____ Doctor Signature and Date

_____ Update by Doctor

_____ Update by Doctor