



Simply put, that means your child cannot be healthy without good oral health and oral health means more than healthy teeth. New research is pointing to association between chronic oral infections in adults and heart and lung diseases, stroke, low birth-weight and premature births. Association between periodontal disease and diabetes has long been noted. Tooth decay is currently the single most common chronic childhood disease – five (5) times more common than asthma and seven (7) times more common than hay fever.

The mouth reflects general health and well-being. The American Academy of Pediatric Dentistry states one of their core values as “oral health is an inseparable part of the overall health and welfare of the infant, child and adolescent.” Our practice supports these values and philosophies. It is important that we are aware of and understand your child’s overall health history. Please provide the most complete and accurate information as possible when completing your child’s health history information. This information is invaluable as we provide the best dental care and treatment to your child.

HEALTH HISTORY & PATIENT INFORMATION

Child’s Name: _____ **Date:** _____

Reason for bringing your child to the dentist: _____

HEALTH HISTORY:	YES	NO	Reviewer Comments
1. Is your child being treated by a physician at this time?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has your child ever been a patient in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has your child ever received general anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has your child ever been seriously ill?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has your child ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, describe: _____			
6. Is your child allergic to anything? (medicine, food)	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, what? _____			
7. Is your child taking any medicines at this time?	<input type="checkbox"/>	<input type="checkbox"/>	
Is yes, what? _____			
8. Has your child ever been seen by a dentist before?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Has your child ever received fluoride in any form?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, what form? _____			
10. Does your child suck his/her thumb, finger or pacifier?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Does your child brush his/her teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>	
How many times/day? _____			
12. Does your child snore?	<input type="checkbox"/>	<input type="checkbox"/>	

Dental History Summary (Summarize briefly patient's past history and dental experience): _____

Reviewer: _____

Date: _____