1002 Park Ave N, Suite H • Renton, WA 98057 • Phone: (425) 988-2808

CHILD'S HEALTH HISTORY

CHILD'S NAME_____
Last First Initial Nickname

DATE OF BIRTH_____

PARENT'S/GUARDIAN'S NAME_____
Last First Initial

DENTAL HISTORY - Circle the appropriate answer.

1. Is this your child's first visit to a dentist?	YES	NO
2. If not, how long since their last visit to the dentist? _____		
3. Were any x-rays or radiographs taken when your child previously visited the dentist?	YES	NO
4. Does your child eat between meals?	YES	NO
5. Does your child eat sweets, such as candy, soda pop or chewing gum?	YES	NO
6. When does your child brush his/her teeth?		
□ upon arising □ after eating any food □ right after meals □ before going to bed		
7. How does your child receive fluoride?		
□ Community Water level _____ ppm □ Well Water level _____ ppm		
□ Fluoride drops or tablets □ Fluoride rinse or gel		
8. Have any cavities been noticed in the past?	YES	NO
9. Were any teeth (baby or permanent) removed by extraction?	YES	NO
10. Have there been any injuries to teeth such as falls, blows, chips, etc?	YES	NO
If so, describe: _____		
11. Has your child had any problems with dental treatment in the past?	YES	NO
12. Has anyone in the family, including parents, had orthodontics?	YES	NO
13. Has your child ever received a local anesthetic?	YES	NO
14. Has your child ever had occlusal sealants?	YES	NO
15. Does your child think there is anything wrong with his/her teeth?	YES	NO

MEDICAL HISTORY - Circle the appropriate answer.

1. Does your child have a health problem?	YES	NO
2. Is your child under the care of physician?	YES	NO
If yes, since when and why?_____		
_____		
3. Name of physician:_____ Phone:_____		
4. Is your child receiving any medication?	YES	NO
What type?_____		
5. Is your child allergic to penicillin, antibiotics, or other drugs?	YES	NO
6. Is your child allergic to or sensitive to any metals or latex?	YES	NO
7. Does your child have other allergies?	YES	NO
8. Has your child had any serious illness?	YES	NO
When?_____ What?_____		
9. Has your child ever had surgery?	YES	NO
10. Does your child have a heart murmur?	YES	NO
11. Is surgery contemplated?	YES	NO
12. Does your child experience severe or prolonged bleeding?	YES	NO
13. Does your child have AIDS or tested HIV positive?	YES	NO
14. Has your child tested positive for hepatitis or TB?	YES	NO
15. Is your child subject to nervous disorders?	YES	NO
☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?		
16. Does your child have frequent headaches?	YES	NO
17. Has your child had history of: (circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.	YES	NO
Any other illness?_____		

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ Date_____

DENTIST'S SIGNATURE _____ Date_____

ANEST.
MED ALERT

COMMENTS