MetLife

CHILD HEALTH HISTORY

English

Today's Date: _____

Patient Name: _____ Patient Nickname: _____

Patient Identification Number: _____ Birth Date: _____ Gender: M F

Patient Address: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Address: _____

Name of Child's Physician: _____ Physician's Phone: _____

I. PLEASE CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1. Yes No Is your child's general health good?
2. Yes No Was your child born prematurely? If YES, how many weeks? _____
3. Yes No Has your child been hospitalized or had surgery?
   If YES, explain: _____
4. Yes No Is your child being treated by a physician now? Date of last medical exam: _____
   If YES, for what? _____
5. Yes No Does your child take any medicine/medications? (e.g. prescription/over the counter/herbal/cream/vitamins/probiotics)
   If YES, what? _____
6. Yes No Does your child have any allergies to drugs, food, other (e.g., latex)?
   If YES, what and explain type/severity of reaction? _____
7. Yes No Has your child had problems with prior dental treatment? Date of last dental exam: _____
   If YES, please explain: _____
8. Yes No Is your child in pain now or having a problem with his or her teeth? _____

II. DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

9. Yes No Asthma or trouble breathing?
10. Yes No Ear aches or ear problems?
11. Yes No Hearing problems?
12. Yes No Eye problems?
13. Yes No Speech problems?
14. Yes No Sinus problems?
15. Yes No Cleft lip / cleft palate?
16. Yes No Apnea / snoring?
17. Yes No Heart murmur or other heart problems?
18. Yes No Rheumatic fever or rheumatic heart disease?
19. Yes No Skin problems? (e.g. eczema, hives, impetigo)
20. Yes No High blood pressure?
21. Yes No Cystic fibrosis?
22. Yes No Ulcers or stomach problems?
23. Yes No Eating disorder / unusual diet?
24. Yes No Hepatitis, jaundice, liver disease?
25. Yes No Weight loss?
26. Yes No Prolonged diarrhea?
27. Yes No Bladder or kidney problems?
28. Yes No Arthritis or joint problems?
29. Yes No TMJ or jaw joint problems?
30. Yes No Scoliosis or spine problems?

III. DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

31. Yes No Fainting or dizziness?
32. Yes No Autism?
33. Yes No Developmental delays or growth delays?
34. Yes No Learning disorders?
35. Yes No Attention deficit / hyperactivity disorder (ADHD)?
36. Yes No Mental problems or behavior disorders?
37. Yes No Brain or head injury?
38. Yes No Psychiatric treatment?
39. Yes No Diabetes / high blood sugar?
40. Yes No Thyroid problems?
41. Yes No Anemia?
42. Yes No Blood disorder or transfusion?
43. Yes No Excessive bleeding / hemophilia?
44. Yes No Sickle cell disease or trait?

IV. DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

45. Yes No Cerebral palsy?
46. Yes No Epilepsy, convulsions or seizures?
47. Yes No Headaches or migraines?
48. Yes No Hydrocephaly or shunts?
49. Yes No Radiation treatment? Please list to what parts of the body and when: _____
50. Yes No Cancer or tumor?
51. Yes No Immune disorder?
52. Yes No Chemotherapy?

V. DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

53. Yes No Measles / Rubella?
54. Yes No Mumps?
55. Yes No Chicken pox / Varicella?
56. Yes No Scarlet fever?
57. Yes No Mononucleosis?
58. Yes No Strep throat
59. Yes No Tuberculosis (TB)?
60. Yes No Whooping cough / Pertussis?
61. Yes No Cytomegalovirus (CMG)?
62. Yes No HIV / AIDS?
63. Yes No Problem with general anesthesia?

VI. DOES YOUR CHILD OR HAS YOUR CHILD:

64. Yes No Smoke tobacco?
65. Yes No Chew tobacco or snuff?
66. Yes No Use recreational drugs?
67. Yes No Use alcohol?

VII. FEMALES (TEENS) ONLY:

68. Yes No Is your child taking birth control pills?
69. Yes No Could your child be pregnant?

VIII. ALL PATIENTS:

70. Yes No Does your child have or has your child had any other diseases, medical problems or syndromes NOT listed on this form?
If YES, please explain: _____
71. Yes No Does your child play organized sports?
If YES, please explain: _____
72. Yes No Does your child wear a helmet or mouthguard when playing either recreational or organized sports?
If YES, please explain: _____
73. Yes No Is your child up to date on all vaccinations?
Don't know

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my child's health and/or medication.

Parent or Guardian's signature: _____ Date: _____

Relationship to the patient: _____

RECALL REVIEW:

Parent or Guardian's signature: _____ Date: _____

Parent or Guardian's signature: _____ Date: _____

The Health History is created and maintained by Dr. James Crall DDS, MS, ScD, Professor & Chair, Section of Pediatric Dentistry UCLA, School of Dentistry.
Support for the translation and dissemination of the Health History comes from MetLife.