

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

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

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

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

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

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

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

**VI. DOES YOUR CHILD OR HAS YOUR CHILD:**

- |     |     |    |                        |     |     |    |                         |
|-----|-----|----|------------------------|-----|-----|----|-------------------------|
| 64. | Yes | No | Smoke tobacco?         | 66. | Yes | No | Use recreational drugs? |
| 65. | Yes | No | Chew tobacco or snuff? | 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 Don't know Is your child up to date on all vaccinations?

*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.

NORWELGIAN  
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