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/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	Rheumatic 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?
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 C[illegible] DDS, MS, ScD, Professor & Chair, Section of Pediatric Dentistry UCLA, School of Dentistry.
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