### 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?  
3. **Yes**  **No**  Has your child been hospitalized or had surgery?  
4. **Yes**  **No**  Is your child being treated by a physician now?  
5. **Yes**  **No**  Does your child take any medicine/medications? (e.g. prescription/over the counter/herbal/cream/vitamins/probiotics)  
6. **Yes**  **No**  Does your child have any allergies to drugs, food, other (e.g., latex)?  
7. **Yes**  **No**  Has your child had problems with prior dental treatment?  
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**  Heart murmur or other heart problems?  
17. **Yes**  **No**  Rheumatic fever or rheumatic heart disease?  
18. **Yes**  **No**  Eye problems?  
19. **Yes**  **No**  Speech problems?  
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 anestheisa?
### VI. DOES YOUR CHILD OR HAS YOUR CHILD:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>64. Smoke tobacco?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65. Chew tobacco or snuff?</td>
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<td></td>
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<tr>
<td>66. Use recreational drugs?</td>
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<tr>
<td>67. Use alcohol?</td>
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</tbody>
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### VII. FEMALES (TEENS) ONLY:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>68. Is your child taking birth control pills?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69. Could your child be pregnant?</td>
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### VIII. ALL PATIENTS:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>70. Does your child have or has your child had any other diseases, medical problems or syndromes NOT listed on this form?</td>
<td></td>
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<tr>
<td>71. Does your child play organized sports?</td>
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<tr>
<td>72. Does your child wear a helmet or mouthguard when playing either recreational or organized sports?</td>
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<tr>
<td>73. Is your child up to date on all vaccinations?</td>
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</table>

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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: ____________________________

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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. Crall DDS, MS, ScD, Professor & Chair, Section of Pediatric Dentistry UCLA, School of Dentistry. Support for the translation and dissemination of the Health Histories comes from MetLife.