**CHILD HEALTH HISTORY**

**Today’s Date:**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Patient Nickname:</th>
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<table>
<thead>
<tr>
<th>Patient Identification Number:</th>
<th>Birth Date:</th>
<th>Gender: M</th>
<th>F</th>
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<table>
<thead>
<tr>
<th>Patient Address:</th>
<th>Parent/Guardian Name:</th>
<th>Phone:</th>
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<thead>
<tr>
<th>Parent/Guardian Address:</th>
<th>Name of Child’s Physician:</th>
<th>Physician’s Phone:</th>
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**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:
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**  Apron / 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**  Ulcers or stomach problems?
22. **Yes**  **No**  Eating disorder / unusual diet?
23. **Yes**  **No**  Hepatitis, jaundice, liver disease?
24. **Yes**  **No**  Weight loss?
25. **Yes**  **No**  TMJ or jaw joint problems?
26. **Yes**  **No**  Prolonged diarrhea?
27. **Yes**  **No**  Bladder or kidney problems?
28. **Yes**  **No**  Arthritis or joint problems?
29. **Yes**  **No**  Eating disorder / unusual diet?
30. **Yes**  **No**  Scoliosis or spine problems?
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?
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?
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:**

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

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<tr>
<th>Question</th>
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<th>Question</th>
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<th>No</th>
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<tr>
<td>68. Is your child taking birth control pills?</td>
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<td>69. Could your child be pregnant?</td>
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**VIII. ALL PATIENTS:**

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<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Question</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>
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<td>71. Does your child play organized sports?</td>
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<td>71. Does your child play organized sports?</td>
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<td>If YES, please explain:</td>
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<td>72. Does your child wear a helmet or mouthguard when playing either recreational or organized sports?</td>
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<td>If YES, please explain:</td>
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<td>73. Is your child up to date on all vaccinations?</td>
<td>Don’t know</td>
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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: ___________________________

**RECALL REVIEW:**

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<tr>
<th>Question</th>
<th>Yes</th>
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Parent or Guardian’s signature: ___________________________ Date: ___________________________

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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 Histories comes from MetLife.