

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? | 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 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 transition and dissemination of the Health History comes from MetLife.

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