Time 11:17 AM | Rogers Dental Center | Date 10/29/2018

Children Health History Form #1

Patient Name: | Birth Date: | Date Created:

Dental History

Date of last visit

Does your child drink juice or Soda? If so how much per day? ◯ Yes ◯ No If yes

Does your child drink Milk? If so how much per day? ◯ Yes ◯ No If yes

What kind of water does your child drink?

☐ City Water ☐ Well Water ☐ Bottled Water

Dental Habits

Does your child brush their teeth daily? ◯ Yes ◯ No

Does your child floss daily? ◯ Yes ◯ No

Does your child

Suck thumb? ◯ Yes ◯ No

bite nails? ◯ Yes ◯ No

Use pacifier? ◯ Yes ◯ No

How has your child responded to previous dental visits?

☐ Very Well ☐ Moderately Well ☐ Moderately Low ☐ Very Poorly

Medical History

Child's Physician and Clinic name:

When was your child's last medical exam?

Are your child's immunizations up-to-date? ◯ Yes ◯ No

Has your child required hospitalization or had serious illness? If yes, Please explain: ◯ Yes ◯ No If yes

Is your child sensitive/allergic to anything? If yes, Please explain: ◯ Yes ◯ No If yes

Is your child taking any medications? If yes, Please explain: ◯ Yes ◯ No If yes

Please check any of the following that apply to your child?

Anaphylaxis	◯ Yes ◯ No	Epilepsy / Sezures	◯ Yes ◯ No	Irregular Heatbeat	◯ Yes ◯ No
ADD /ADHD	◯ Yes ◯ No	Fainting	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No
Autism / Aspergers	◯ Yes ◯ No	Hearing Impairement	◯ Yes ◯ No	Measles	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Artificail HeartValve	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Mumps	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Hepatitis B	◯ Yes ◯ No	Spins Bifida	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hepatitis C	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chemotherapy /Radiation	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Chicken Pox	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
-	◯ Yes ◯ No	-	◯ Yes ◯ No	Diabeties	◯ Yes ◯ No

Are there any other illnesses not listed? ◯ Yes ◯ No If yes

Emergency Contact

Signature of Patient, Parent or Guardian:

X Date:_____