Han Pediatric Dentistry

HEALTH HISTORY FORM

Child's medical doctor: _____ Address: _____ Phone: _____

Date of last physical _____

	Yes	No
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐

IF "NO," YOU WILL NEED TO PROVIDE A MEDICAL DOCTOR'S EXEMPTION LETTER FOR VACCINATIONS.
In the interest of public safety and the protection of our medically compromised patients, our practice cannot accommodate patients who are electively unvaccinated.

Is your child currently being treated for any medical conditions?	☐	☐
If yes, explain:_____		
Is your child taking any prescription or over-the-counter medication?	☐	☐
If yes, explain: _____		
Has your child ever been hospitalized or had surgery?	☐	☐
If yes, explain:_____		
Is your child scheduled to have any upcoming surgery?	☐	☐
If yes, explain: _____		
Has your child ever had complications from general anesthesia?	☐	☐
If yes, explain: _____		
Does your child have any allergies or reactions to any medications?	☐	☐
If yes, explain: _____		

Does your child have any allergies to the following: ☐ Latex ☐ Food ☐ Dyes ☐ Other _____

Has your child ever had any history of, or conditions related to any of the following?

- ☐ Acid reflux/GERD
- ☐ ADHD
- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Asthma/lung problems
- ☐ Autism
- ☐ Auto-immune disease
- ☐ Bladder conditions
- ☐ Birth defects
- ☐ Bleeding disorders/transfusions
- ☐ Bone or joint problems
- ☐ Brain injury
- ☐ Bruising easily
- ☐ Cancer or malignancies
- ☐ Cerebral palsy
- ☐ Chemotherapy/radiation treatment
- ☐ Child abuse
- ☐ Chronic infection of tonsils/adenoids
- ☐ Chronic headaches/migraines
- ☐ Chronic ear infections
- ☐ Chronic pain
- ☐ Cleft lip and/or palate
- ☐ Convulsions/seizures (epilepsy)
- ☐ Diabetes
- ☐ Eye problems
- ☐ Endocrine (hormonal) problems
- ☐ Excessive gag reflex
- ☐ Fainting/dizziness
- ☐ Frequent infections
- ☐ Growth & development problems
- ☐ Hearing/speech problems
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis (liver disease)
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Low birth weight (_____ lbs)
- ☐ Mental/emotional disturbances
- ☐ Nutrition deficiencies
- ☐ Oral ulcers
- ☐ Orthopedic problems
- ☐ Premature birth (_____ weeks) Pregnancy (teens)
- ☐ Rheumatic fever
- ☐ Scoliosis/spinal problems
- ☐ Sexually transmitted diseases
- ☐ Sickle cell anemia
- ☐ Sinus infections (chronic)
- ☐ Sleep apnea
- ☐ Spina bifida
- ☐ Stroke
- ☐ Syndrome
- ☐ Thyroid/metabolic problems
- ☐ Tobacco or other drug use
- ☐ Serious traumatic injury
- ☐ Tuberculosis
- ☐ Viral infections (including SARS or COVID-19)

Please explain past history of any conditions checked above:

_____

Does your child have, previously or presently, any other diseases or medical problems NOT listed on this form?

☐ Yes ☐ No If yes, explain: _____

DENTAL HISTORY

	Yes	No	
Was your child bottle fed?	☐	☐	If yes, until what age? _____
Was your child breast fed?	☐	☐	If yes, until what age? _____
Has your child had any injuries to the face, jaws, mouth, or teeth?	☐	☐	
If yes, describe: _____			
Do the child's parents have history of dental disease?	☐	☐	
Does your child like to snack during the day?	☐	☐	If yes, how often? _____times/day
Does your child drink juices/soda/sweetened drinks?	☐	☐	If yes, how often?_____ times/day
How many times a day does your child brush?	_____ times/day		
Does an adult assist with the brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with the flossing?	☐	☐	

Does your child have any of the following oral habits?

☐ Finger sucking ☐ Pacifier ☐ Lip sucking ☐ Teeth grinding
☐ Thumb sucking ☐ Tongue thrusting ☐ Mouth breather ☐ Other _____

How does your child receive fluoride? (Check all that apply):

☐ Vitamins ☐ Water supply ☐ Tablets/drops (dosage: _____mg/day) ☐ Toothpaste ☐ Rinse/gel

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I certify that I have read and understand the medical and dental history forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any changes in my child's health and/or medication. Further, I will not hold the dentist, or any member of the office staff, responsible for any errors or omissions that I may have made in the completion of this form.

The practice of pediatric dentistry involves treating the whole person. If the dentist determines that there may be a medically compromised situation, additional studies or a consultation may be needed prior to commencement of treatment. I authorize the doctors and staff of Han Pediatric Dentistry to release information and to contact my child's physician and other health care professionals for the purposes of my child's health care.

Name: _____ Relationship to Patient: _____ Date: _____

Signature: _____