Children's Health History Form

Child's Legal Name: _____ **Nickname:** _____ **Birth date:** ____/____/____
(FIRST) (MI) (LAST)

Gender Identity: M/F/Other *(please specify)*: _____ **Pronouns:** He, Him, His / She, Her, Hers / They, Them, Theirs

School: _____ **Grade:** ____ **E-mail** *(to confirm appointments)*: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Parents' Marital Status: Married Separated Divorced Remarried Widowed Single

Mother's Information Name: _____ Spouse's Name *(if different than father)*: _____

Address (*if different than child's*): _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Father's Information Name: _____ Spouse's Name *(if different than mother)*: _____

Address (*if different than child's*): _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Medical History

Pediatrician: _____ Other treating specialist: _____

Y N Does your child have any health issues? _____

❑ ADD/ADHD ❑ Anxiety/depression ❑ Asthma ❑ Autism Spectrum Disorder
❑ Bleeding disorders ❑ Cancer ❑ Diabetes ❑ Eczema
❑ Gastric reflux ❑ Heart disease ❑ Seasonal Allergies ❑ Seizures
❑ Other, explain _____

Y N Is there any significant birth history? *(Please explain)* _____

Y N Has your child had any surgeries or hospitalizations? *(Please specify with w/ approx. dates)* _____

_____

Y N Does your child have any allergies to foods or medications? *(Specify)* _____

Y N Does your child take any medications? *(Please list all including vitamins)* _____

Y N Does your child have any emotional/behavioral or learning disorders? _____

_____

Dental History

Does your child presently have any of the following habits?

❑ Pacifier ❑ Thumb habit ❑ Finger habit ❑ Lip biting ❑ Nail biting ❑ Grinding

⇨ If habit has stopped, at what age? _____

Has your child had a toothache recently? Y N

Has either parent had a lot of tooth decay? Y N

Do you have any concerns about your child's mouth? Y N

Has your child been to an orthodontist? If yes, whom? _____ Other family members? _____

Does your child have any speech issues? *(Please explain)* _____

Does your child play any sports? Y N If yes, do they wear an athletic mouth guard? Y N

Oral Health Habits

Does your child receive fluoride in any of the following forms?

❑ Toothpaste ❑ Water ❑ Tablets ❑ Drops ❑ Rinses ❑ Other _____

What kind of toothbrush does your child use? ❑ Manual ❑ Electric

How often does your child brush each day? ❑ 1x/day ❑ 1-2x/day ❑ 2x/day

When do you assist your child? ❑ Morning ❑ Night ❑ Not assisting

Does your child floss? Y N If yes, how often? _____

Please list kinds of snacks your child enjoys? _____

Form completed by _____ Signature _____ Date ___/___/___

Dentist's Signature _____ Date ___/___/___