

# Children's Health Record

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name of Parent / Guardian \_\_\_\_\_ Daytime Phone \_\_\_\_\_

## Medical History

General Health: \_\_\_\_\_ excellent \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Are you currently taking any medication? ..... Y \_\_\_\_\_ N \_\_\_\_\_

If yes, what, and for what purpose? \_\_\_\_\_

Are you allergic to: \_\_\_\_\_penicillin \_\_\_\_\_ local anesthetics \_\_\_\_\_fluoride \_\_\_\_\_other

Do you have, or have you ever been informed of having:

|                                 | Y                        | N                        |                        | Y                        | N                        |
|---------------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| Heart disease/defects . . . . . | <input type="checkbox"/> | <input type="checkbox"/> | Asthma . . . . .       | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever . . . . .       | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy . . . . .     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur . . . . .          | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice . . | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal Blood Pressure . . .   | <input type="checkbox"/> | <input type="checkbox"/> | Cancer . . . . .       | <input type="checkbox"/> | <input type="checkbox"/> |

Is there any medical condition or consideration not listed here that we should be aware of? \_\_\_\_\_

## Dental History

Date of last dental visit \_\_\_\_\_ Were x-rays taken? ..... Y \_\_\_\_\_ N \_\_\_\_\_

Are you aware of any problems with your teeth or gums at this time? ..... Y \_\_\_\_\_ N \_\_\_\_\_

Do you have trouble breathing through your nose? ..... Y \_\_\_\_\_ N \_\_\_\_\_

Are you interested in orthodontic treatment? ..... Y \_\_\_\_\_ N \_\_\_\_\_

Have you had any problems associated with previous dental treatment? ..... Y \_\_\_\_\_ N \_\_\_\_\_

If yes, please explain \_\_\_\_\_

*I certify that the above questions have been answered accurately and to the best of my knowledge.*

X \_\_\_\_\_  
*Signature of parent or guardian* *Date*