

F O R T W O R T H  
 pediatric  
 D E N T I S T R Y

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Patient Health History

The following information is requested to enable us to give the most consideration to your time and feelings. It is our sincere desire to give personal attention to each of our patients and parents.

Child's Name: \_\_\_\_\_ M  F  Pediatrician: \_\_\_\_\_

Nickname: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does your child have any health issues? Yes  No  Is your child seeing any other specialist? Yes  No

Does your child take any medicine(s) regularly? Yes  No

If yes, please list: \_\_\_\_\_

Please check if patient is allergic to any of the following:

Latex  Penicillin  Antibiotics: list type: \_\_\_\_\_  Red Dye  Nuts \_\_\_\_\_

Other: Please specify \_\_\_\_\_

Has your child ever been hospitalized or had any surgical procedures? Yes  No  When: \_\_\_\_\_

Reason? \_\_\_\_\_

Has your had any history of the following or currently being treated for:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> ADHD/ADD                    | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> HIV+/AIDS           | <input type="checkbox"/> Dyslexia          |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Kidney/Liver Issue      | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Behavioral Issues |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Emotional Issues  |
| <input type="checkbox"/> Bleeding disorder           | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Hearing Impairment  | <input type="checkbox"/> Speech Issues     |
| <input type="checkbox"/> Cardiac Issues/Heart Murmur | <input type="checkbox"/> Handicaps/Disabilities  | <input type="checkbox"/> Cleft lip or palate |  |

Other: Please specify \_\_\_\_\_

Does your child display or exhibit any sensory sensitivities? Yes  No

Hyposensitive  Hypersensitive  If so please explain: \_\_\_\_\_

Please explain briefly why you brought your child for dental care: \_\_\_\_\_

Is this your child's first visit to the dentist? Yes  No

If no: Name of previous dentist \_\_\_\_\_ Date of last dental visit \_\_\_\_\_ Were x-rays taken? Yes  No

Has your child experienced any unfavorable reaction from any previous dental care? Yes  No

If yes, explain: \_\_\_\_\_

Does your child have a toothache now? Yes  No

If yes, explain: \_\_\_\_\_

Has your child had a toothache? Yes  No

If yes, explain: \_\_\_\_\_

Does your child have an oral habit?  Pacifier  Finger(s)  Thumb  Other: \_\_\_\_\_

Does your child use a:  Bottle  Sipper Cup

I understand that I am responsible for notifying this office of any accidents, major illnesses or changes in medical history of the above named child. I certify that the above health history is accurate and complete to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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