FORT WORTH
pediatric
DENTISTRY

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Diplomate of the American Board of Pediatric Dentistry

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? _____

Is your child up-to-date on immunizations? Yes ☐ No ☐

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

☐ ADHD/ADD	☐ Diabetes	☐ HIV+/AIDS	☐ Dyslexia
☐ Anemia	☐ Kidney/Liver Issue	☐ Tuberculosis	☐ Behavioral Issues
☐ Asthma	☐ Lung Disease	☐ Epilepsy/Seizures	☐ Emotional Issues
☐ Bleeding disorder	☐ Rheumatic/Scarlet Fever	☐ Hearing Impairment	☐ Speech Issues
☐ Cardiac Issues/Heart Murmur	☐ Handicaps/Disabilities	☐ 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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