



Pediatric Dentistry Health History

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Child's Name (First, Middle Int, Last) _____ DOB _____

Child's pediatrician _____ Phone No. _____ Last Physical _____

Is your child under a physician's care now? Y/N Reason _____ Has your child received all immunizations? Y/N

Is your child taking any medication? Y/N What kind _____ Reason _____

Is your child allergic to any medications? Y/N Please list _____

Has your child ever been hospitalized? Y/N Reason _____

Phobias: _____ Does your child have any special needs? _____

Your child's interests? _____

Any allergic reactions to: eggs Y/N soy Y/N foods Y/N pollen Y/N
 dust Y/N latex Y/N animals Y/N other _____

Has your child had a history or difficulty with any of the following:

- | | | | |
|---------------------|---------------------------|------------------------|----------------------------|
| Y/N Premature birth | Y/N Earaches | Y/N Speech | Y/N Nosebleeds |
| Y/N Heart | Y/N Kidney | Y/N Hearing | Y/N Asthma |
| Y/N Seizures | Y/N Bleeding | Y/N Brain injury | Y/N Liver |
| Y/N Immune disorder | Y/N Cerebral Palsy | Y/N Bruising | Y/N Bone disorder |
| Y/N Anemia | Y/N Fainting or dizziness | Y/N Rheumatic fever | Y/N Tuberculosis |
| Y/N Diabetes | Y/N ADD/ADHD | Y/N Emotional problems | Y/N Cancer or malignancies |
| Y/N Hepatitis | Y/N Delayed development | Y/N Autism | Y/N Bladder |

Any medical condition not on this form _____

Dental History:

Reason for today's visit _____ Child's previous dentist _____

Child's attitude toward previous dental care? _____ Family's dentist _____

Does your child brush/floss daily? Y/N Does an adult assist with brushing/flossing? Y//N

Is/Was your child breast fed? Y/N If Yes, for how long? _____

Is/Was your child bottle fed? Y/N If Yes, for how long? _____

Has your child had any injuries to teeth, mouth, or head? Y/N Describe _____

Habits: finger/thumb sucking Y/N pacifier Y/N lip sucking Y/N mouth breathing Y/N
 snoring Y/N nail biting Y/N teeth grinding Y/N other _____

How may we help to make this visit a positive experience for your child? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are any changes in my child's health status, I will inform the doctor at the next appointment without fail.

SIGNATURE _____ Relationship _____ Date _____

Please do not write below this line

Doctor's Comments: _____ Today's Date: _____

CC: _____

OH: _____

Dhx/CRA: _____

Diet: _____

Habits: _____

Mhx: _____