Ravenna Family Dentistry
CHILD'S HEALTH HISTORY FORM
(Confidential)

Today's Date_____

Child's Name: Last_____First_____MI_____ Birthdate_____

DENTAL HISTORY

Reason for today's visit _____
Former dentist (if applicable) _____ Location_____
Date of last dental care _____ Date of last dental xrays _____

	YES	NO	Unsure
Has your child complained about dental problems?	____	____	____
Do you assist/help you child with toothbrushing and flossing?	____	____	____
Is your child's water fluoridated?	____	____	____
Does your child take prescription fluoride supplements?	____	____	____
Any injuries to mouth, teeth, or head?	____	____	____
Any unhappy dental experiences?	____	____	____
Any mouth habits (ie thumbsucking, nail biting, mouth breathing, Pacificier, or sleeping with a bottle)	____	____	____
Does your child drink sweetened pop/soda, juice, or vitamin water?	____	____	____

How often does your child brush his/her teeth?_____How about floss?_____

MEDICAL HISTORY

Child's Physician/Pediatrician Name_____Location_____
Date of last visit to physician?_____ Child's weight_____
Does your child have or have they ever had:

__Anemia __Abnormal heart condition/surgery __Asthma __Hepatitis
__Diabetes/insulin pump __Abnormal bleeding from a cut __Tuberculosis __HIV/AIDS
__High blood pressure __Epilepsy/Convulsions/Seizures __Other conditions not listed

Does your child's physician request that they premedicate (take antibiotics) before any dental procedures? _____

MEDICATIONS

Is any medication being taken now? _____ If so, please list medication along with dosage, frequency, and reason for taking:
_____
_____
Preferred pharmacy _____ Phone _____

ALLERGIES

Does your child have any of the following allergies?

__Aspirin __Penicillin __Ibuprofen/NSAIDs __Foods
__Codeine __Sulfa __Local anesthetic __Jewelry/metals (ex Nickel, Copper)
__Other, please list _____

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I will not hold the dentist or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature of parent/guardian_____

MEDICAL HISTORY UPDATE

Has there been any changes in your child's health since their last dental appointment? ___Yes ___No
If so, for what conditions? ____
Is the child taking any new medications?___ If so, which ones?__________________________________
Does your child have any new allergies?___ If so, to what? _____________________________________
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