

CHILD'S HEALTH HISTORY UPDATE

Child's Name: _____ Date: _____

Father's Full Name: _____ Mother's Full Name: _____

Are you the child's legal guardian? Yes No

Since the child's last appointment have there been any changes in his/her health? If yes, Please Explain: _____

1. Is there anything about your child's teeth, mouth or jaw that concerns you? If yes, What? _____ Yes No2. Do you have any other concerns about today's appointment that you would like to bring to the doctor's attention? Yes No
If yes, What? _____3. Is your child presently under the care of a physician for any medical reasons? Yes No
If yes, What? _____4. Is your child taking any medications? If yes, What? _____ Yes No5. Does your child have a medical condition (heart murmur, heart defect, etc) that requires antibiotics before dental treatment? Yes No
If so, has your child taken the prescribed medication? If yes, What? _____ How much? _____ What time? _____6. Is your child allergic to a medicine or other product? If yes, What? _____ Yes No7. Is your child allergic to vinyl, metal or acrylics? If yes, What? _____ Yes No8. Is your child allergic to latex (balloons, rubber products)? If yes, What? _____ Yes No

SIGNATURE OF PARENT/GUARDIAN: _____ DOCTOR'S INITIAL: _____

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