Child Health Questionnaire

Today's Date _____

Full Name * _____ SSN _____ email _____

Birthdate _____ Age _____ Sex Unkno Home Phone # _____

Address _____ Work Phone # _____

, _____ Cell Phone # _____

Child's Physician _____

Physician's Phone # _____

Date of last physical examination _____

Has your child had any serious illness, hospitalization, or accident? Yes ☐ No ☐

If yes, describe: _____

For Office Use Only:

BP _____ mmHg

Pulse _____ bpm

Weight _____ lbs.

Has your child ever had an allergic reaction to the following:

Dental Anesthetics ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin/Ibuprofen ☐ LATEX ☐

Other Antibiotics ☐ Dyes ☐ Food ☐ Tylenol ☐ Other Medications ☐ None ☐

Has your child ever had any of the following conditions? *Please circle the ones that may apply:*

Heart Disease	Hepatitis	Cancer	Mononucleosis	Sleep Apnea
Heart Murmur	Liver Disease	Learning Disability	Tuberculosis	Snoring
Rheumatic Fever	Lung Disease	Autism	Recent Infection	Depression
Hypertension	Asthma	Hearing Problems	Whooping Cough	Anxiety
Scarlet Fever	Kidney Disease	ADD/ADHD	Current on Vaccines	Mental Health Disorder
Epilepsy	Thyroid Problem	Eating Disorder	AIDS or HIV+	Bleeding Problems
Seizures	Diabetes	GERD	Sickle Cell Anemia	Other

Medications:

Does your child have any habits we should know about, such as:

Thumb Sucking ☐ Pacifier ☐ Bottle ☐ Other _____

Does your child receive fluoride in: Drinking water ☐ Toothpaste ☐ Oral rinse ☐

Has your child has any unpleasant dental experience? Yes ☐ No ☐

How can we help? _____

Date of last dental examination _____

Has your child ever had orthodontic treatment? Yes ☐ No ☐

What is the reason for today's visit? Routine Exam ☐ Emergency ☐ State Problem: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the doctor of any changes in my child's health or medication.

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Signature of Parent/Guardian: Signature of Doctor/Staff:

Welcome and thank you for letting us care for your child's smile!

COVE

ChoiceDental

When quality and comfort matter, the CHOICE is simple.