Children's Health Record

Name _____ Date of Birth ____/_____/_____ SSN _____ - ____- _____

Name of Parent / Guardian _____ Daytime Phone _____

Medical History

General Health: ____ excellent ____ good ____ fair ____ poor

Name of Physician _____ Phone _____

Address _____

Are you currently taking any medication? …….. Y ____ N____

If yes, what, and for what purpose? _____

Are you allergic to: ____penicillin ____ local anesthetics ____fluoride ____other

Do you have, or have you ever been informed of having:

	Y	N		Y	N
Heart disease/defects	☐	☐	Asthma	☐	☐
Rheumatic Fever	☐	☐	Epilepsy	☐	☐
Heart Murmur	☐	☐	Hepatitis/Jaundice	☐	☐
Abnormal Blood Pressure . . .	☐	☐	Cancer	☐	☐

Is there any medical condition or consideration not listed here that we should be aware of ?_____

_____

Dental History

Location/ Date of last dental visit _____ Were x-rays taken? ……Y____ N____

Are you aware of any problems with your teeth or gums at this time? ……...Y____ N____

Do you have trouble breathing through your nose? ……Y____ N____

Are you interested in orthodontic treatment? ……..Y____ N____

Have you had any problems associated with previous dental treatment? ……...Y ____ N____

If yes, please explain _____

I certify that the above questions have been answered accurately and to the best of my knowledge.

*X*_____

Signature of parent or guardian *Date*