Child Health History Form

Patient Name:_____ Birthdate:_____

First Middle initial Last M M / D D / Y Y Y Y

Address:_____

Street City State Zip

Dental and Medical History

Main dental concern_____

Is the child taking any medications (please list)_____

Allergies?_____**Please discuss**_____

Heart problems?_____**Please discuss**_____

Blood problems?_____**Please discuss**_____

Kidney or Liver problems_____**Please discuss**_____

Handicaps/Disabilities_____**Please discuss**_____

Diabetes?_____ **Asthma?**_____ **Thumb sucking?**_____ **Pregnant?**_____ **How far along?**_____

_____

Date Print parent/Guardian name Signature parent/ Guardian Relationship to patient