THE DENTAL PRACTICE

Pediatric Health History

Patient Name _____ **Age** ____ Height: _____Weight: _____

Mother's Name: _____ Father's Name:_____
Other Legal Guardian (if applicable): _____
Physician's Name: _____
Date of Last Dental visit: _____
Whom may we thank for referring you? _____
How can we help your child today? _____

PLEASE CIRCLE YOUR ANSWER

Does your child brush their teeth daily?	YES	NO
Any previous unhappy dental visits?	YES	NO
Any injuries to teeth, face, or jaw?	YES	NO
Is your child receiving/taking any medications?	YES	NO

If yes, please list here:

Does your child have any allergies?	YES	NO

If yes please list here (foods, latex, metals, medicines):

Has your child had surgery or been hospitalized?	YES	NO

If yes, for what reason?

Does your child breathe more through their mouth or nose?	MOUTH	NOSE
Does your child snore when sleeping?	YES	NO
Does your child have frequent headaches in the morning?	YES	NO
Does your child grind their teeth?	YES	NO
Does your child wet the bed?	YES	NO
In your opinion, is your child NOT reaching their full potential at school?	YES	NO
Is your child hyperactive, have trouble listening or have attention deficit?	YES	NO
Does your child sweat excessively while sleeping?	YES	NO
Does your child have frequent throat infections or have large tonsils?	YES	NO
Does your child suck their finger(s)?	YES	NO
Has your child used a pacifier in the past or currently use one?	YES	NO
Is it difficult to understand your child's speech?	YES	NO

Does your child have a history of any brain, heart, lung, stomach, colon, blood sugar, bleeding, bladder, liver, developmental, or neurologic disorders?
Any other health concerns we need to know about?
If yes, please explain here:

The team at The Dental Practice takes a whole-body approach to your child's care. Please ask your provider for more information on how the health of the mouth affects the rest of your body.

Parent Signature: _____Date: _____