

**CHILD HEALTH HISTORY**

**PERSONAL**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_ M / F

Preferred Name/Nickname (if any) \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_ Father's Full Name: \_\_\_\_\_

Child's Interests/Hobbies: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your child's mouth, their mouth is a part of their entire body. Health problems that they may have, or medication that they may be taking, could have an important interrelationship with the dentistry they will receive. Thank you for answering the following questions.

**MEDICAL HISTORY** Please circle (Y) Yes or (N) No

- Is your child under a physician's care now? Y N If yes, please explain: \_\_\_\_\_
- Has your child ever been hospitalized or had a major operation? Y N If yes, please explain: \_\_\_\_\_
- Has your child had a serious head or neck injury? Y N If yes, please explain: \_\_\_\_\_
- Has your child ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Y N If yes, please explain: \_\_\_\_\_
- Is your child on a special diet? Y N If yes, please explain: \_\_\_\_\_

**Allergies:** Are you allergic to any of the following? (Please circle any applicable answers)

Aspirin Penicillin Codeine Acrylic Other: \_\_\_\_\_  
 Metal Latex Sulfa Drugs Local Anesthetics \_\_\_\_\_

Please explain your reaction: \_\_\_\_\_

**Does your child have, or has he/she ever had any of the following?** Please check the box next to the applicable answer.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Cortisone Medicine    | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Radiation Treatments       |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Recent Weight Loss         |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Drug Addiction        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Easily Winded         | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Epilepsy or Seizures  | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Excessive Thirst      | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fainting/Dizziness    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Cough        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Diarrhea     | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Venereal Disease           |
|  |  |  | <input type="checkbox"/> Yellow Jaundice            |

Has your child ever had any serious illness not listed above? \_\_\_\_\_  
 If you answered yes to any of the above, please explain: \_\_\_\_\_

**Please list any medications your child is currently taking (including over-the-counter, vitamins, natural remedies):**  
**(You may also attach a list.)**

\_\_\_\_\_  
 \_\_\_\_\_

**DENTAL HEALTH HISTORY (Ages 5-15 years old)**

Reason for today's visit: \_\_\_\_\_  
Former Dentist: \_\_\_\_\_ City/State: \_\_\_\_\_  
Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

A child's dental health is affected by many different things. The three most important to developing teeth are home care (tooth brushing, flossing and the use of fluoride), any habits relating to the mouth or teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions:

**Does your child have or have they ever had, any of the following?** *Please check the box next to the applicable answer.*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad breath                     | <input type="checkbox"/> Sensitivity to sweets              | <input type="checkbox"/> Chew on any foreign objects (e.g. toothpicks)                     |
| <input type="checkbox"/> Blisters on lips or mouth      | <input type="checkbox"/> Sensitivity when biting or chewing | <input type="checkbox"/> Mouth breathing   |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Clicking or Popping Jaw            | <input type="checkbox"/> Difficult or serious problem associated with previous dental work |
| <input type="checkbox"/> Bleeding gums                  | <input type="checkbox"/> Pain/discomfort in the jaw joint   | <input type="checkbox"/> Orthodontic treatment   |
| <input type="checkbox"/> Dry mouth                      | <input type="checkbox"/> Pain around ear                    | <input type="checkbox"/> Retainers   |
| <input type="checkbox"/> Broken fillings                | <input type="checkbox"/> Grinding teeth                     |  |
| <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Fingernail biting                  |  |
| <input type="checkbox"/> Sensitivity to heat            | <input type="checkbox"/> Lip or cheek biting                |  |

Did/does your child suck his/her thumb or finger? YES NO Stopped at age \_\_\_\_\_ Still does \_\_\_\_\_ Only at night \_\_\_\_\_

**Home Dental Care**

Does your child brush his/her own teeth? YES NO How often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week  
 Do you brush your child's teeth? YES NO How often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week  
 How much toothpaste do you use? \_\_\_\_\_ Does your child swallow it? YES NO  
 Does your child use dental floss? YES NO If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ time per week  
 Do you floss your child's teeth? YES NO If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week \_\_\_\_\_ times per \_\_\_\_\_  
 Does your child drink city water, well water, bottled water, or from another source? Please circle your child's main source of water.  
 Does your child drink fluoridated water? YES NO DON'T KNOW If yes, how much fluoride is in the water? \_\_\_\_\_ ppm  
 Does your child take fluoride drops or tablets? YES NO If yes, at what age did he/she start taking them? \_\_\_\_\_  
 Is he/she still taking them? YES NO  
 Does your child use a fluoride mouthwash? YES NO If yes, brand name \_\_\_\_\_  
 Has your child received fluoride treatments at a dental office? YES NO  
 Anything else you would like to add about the care of your child's teeth at home? \_\_\_\_\_

**Diet**

How many meals per day does your child eat? \_\_\_\_\_  
 How many between meal snacks (including drinks other than water) does your child have on an average day? \_\_\_\_\_  
 Does your child chew gum with sugar in it? YES NO If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week  
 Does your child have dried fruit, sticky carbohydrates, hard candies, or suckers? YES NO  
 If yes, please circle the ones that are applicable.  
 Would you like to make any comments about your child's diet? \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Langhorst Family Dentistry, PLLC or Sarah Langhorst, DDS of any changes in medical status.**

Signature of Patient, Parent, or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_