Langhorst Family Dentistry, PLLC • Sarah Langhorst DDS • 3235 N. Wellness Dr. Suite A-240 • Holland, MI 49424 • 616-377-7708

CHILD HEALTH HISTORY

PERSONAL

First Name: _____ Last Name: _____ MI: _____ M / F

Preferred Name/Nickname (if any) _____ Birth Date: _____

Parent's Full Name: _____ Parent'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.*

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

_____

OVER→

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DENTAL HEALTH HISTORY (Less than 5 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:

Habits

Did/does your child suck his/her thumb or finger? YES NO Stopped at age _____ Still does _____ Only at night _____
Does your child grind his/her teeth? YES NO
Does your child have any other tooth related habits? _____

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 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

Was/is your child put to bed with a bottle? YES NO If yes, what was in the bottle? _____
Was/is your child allowed to carry a bottle or cup throughout the day containing something other than plain water? YES NO
Does your child chew gum with sugar in it? YES NO If yes, how often? _____times per day _____times per week
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? _____
If your child is using a pacifier, is it ever dipped in honey or other sweet substances? YES NO
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 Parent or Guardian: _____ Date: _____