The Pediatric Dental Specialists
LAWRENCE & WENG

PERSONAL HEALTH HISTORY OF:

Child's Name _____ Nickname _____

Sex _____ Date of Birth _____ Place _____

Home Address _____
Street City State Zip

Father's Name _____ MR. ___ DR. ___ Other ___

Father employed by _____ Social Security No. _____

Phone: (h)_____ (c)_____ (w)_____ Email:_____

Mother's Name_____ MS. ___ MRS.___ DR.____ Other ___

Mother Employed by _____ Social Security No. _____

Phone (h)_____ (c)_____(w)_____Email:_____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____

Name and birthdates of Other Children: _____

_____

Name and Address of Child's Physician/Pediatrician _____
Name Phone

_____
Address

Name and Address of Previous Dentist and Date of Visit _____
Name Phone

_____
Address Date of Last Visit

Referred by: _____

Is your child covered by dental insurance? ☐ Yes ☐ No

Primary Insurance _____ Group # _____ ☐ Mom ☐ Dad

ID # _____ Subscriber's Date of Birth _____

Secondary Insurance _____ Group #_____ ☐ Mom ☐ Dad

ID # _____ Subscriber's Date of Birth _____

1. Conditions of child's health _____
2. Has your child had …. (circle all that apply)
   Heart trouble, rheumatic fever, glandular problems, brain injury, asthma, seizures, bleeding disorders, skin disorders, ear infections, diabetes, hyperactivity, kidney or liver problem, tuberculosis, headaches, emotional or psychiatric illness.
3. Has your child ever had any hearing, sight, speech, coordination problems or special schooling?
   If so, state what problem is and when it existed. _____
4. Has your child ever been hospitalized? Please list _____
5. Has your child had any kind of surgery? Please list _____
6. Has your child ever received a blood transfusions? _____
7. Does your child have any blood-borne diseases? _____
8. Does your child need antibiotics for dental treatment? _____
9. Please indicate any other health problems. _____
10. Is your child taking any pills or medication now? _____
11. Did your child receive medication as an infant? _____
12. **Is your child allergic to any food or medicine?** _____
13. **Is your child allergic to latex?** _____
14. Was the term of pregnancy and birth normal for your child? _____
    If no, please state any complications or problems including prematurity or low birth weight. _____
15. Is this your child's first visit to the dentist? _____
    If not, when was the last visit to the dentist? _____ Xrays? _____
16. Has your child ever experienced an unfavorable or undesirable reaction to previous dental or medical care? _____
17. Does any member of the family have any missing or extra teeth? _____
18. What do you think of the condition of your child's mouth? _____
19. Are you concerned about any special dental problems now? _____
20. Is your child experiencing any dental pain or discomfort now? _____
21. At what age did teeth first appear? _____ Where? upper _____ lower _____ front _____ back _____
22. Was your child bottle-fed or breast-fed? _____
23. Has there ever been an injury to any of your child's teeth? _____
24. Please circle all habits that your child has ever had: finger-sucking pacifier mouth-breathing grinding other _____
25. Please circle any of the following that are sources of fluoride for your child:
    water toothpaste vitamin supplements fluoride supplements
26. Do you have well water? (if yes, please bring in a sample) _____
27. Is bottled water a primary source of cooking or drinking? _____
28. Please list any questions you would like answered: _____

Your signature indicates that you have completed the health history to the best of your knowledge.

Parent or guardian signature _____ Date _____