

CHILD HEALTH HISTORY

Correct answers to the following questions will allow Dr. Renken to treat you on a more individual basis, providing the care appropriate for your particular needs. All information is completely confidential.

Patient's Name _____ Birth date _____ Age _____

Parent or Guardian's Name _____

Why is child now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Is this the child's first visit to the dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If not, how long since the last visit to the dentist? _____ | | |
| 3. Has child had any unfavorable dental experiences? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has child ever received a local anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, has he/she ever had an allergic reaction to it? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has child ever had occlusal sealants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Name of physician _____ Phone number _____ | | |
| 7. Has child had any serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| When _____ What _____ | | |
| 8. Has child had surgery or is surgery contemplated? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, when _____ What _____ | | |
| 9. Does child have any seasonal allergies or sinus problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is child allergic to any medications such as penicillin, sulfa, latex, or other drugs?
If so, please list the medications _____ | | |
| 11. Is child receiving any medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| What? _____ | | |
| 12. Has child had history of (Circle appropriate responses): diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache | | |
| 13. Does child require premedication? | <input type="checkbox"/> | <input type="checkbox"/> |

I understand the above information is necessary to provide my child with dental care in a safe and effective manner. I understand that the information I have given today is correct to the best of my knowledge. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my child's medical status at the next appointment.

Parent or Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____