OCONOMOWOC pediatric dentistry

Health History

Child's Information			
Last Name:	First:		MI:
Preferred Name:	Date of Birth:	Age:	Gender:
Attend daycare/preschool/school: □ Y □ N	Where:		Grade:
Custodial Parents Name:			
Names of other family members seen in our office:			
Who does child live with: □ Both parents □ Mother □ Father □ Other:_____			

Medical History	
Child's Physician:	Physician's Phone:
Is your child allergic to any of the following: □ Penicillin/Amoxicillin □ Latex □ Nickle □ Nut - Type: _____ □ Medication: _____ □ No known allergies □ Other (food, animals, dust, environmental): _____	

Has your child ever had any of the following: {Please Check}

□ Y	□ N	Anemia	□ Y	□ N	Heart Murmur _____
□ Y	□ N	Asthma	□ Y	□ N	Heart Condition_____
□ Y	□ N	Attention Deficit Disorder	□ Y	□ N	Hepatitis
□ Y	□ N	Autism/Autism Spectrum Disorder	□ Y	□ N	Kidney Disease_____
□ Y	□ N	Bleeding Disorder _____	□ Y	□ N	Learning Disability
□ Y	□ N	Cancer_____	□ Y	□ N	Liver Disease_____
□ Y	□ N	Cerebral Palsy	□ Y	□ N	Pregnant ____weeks
□ Y	□ N	Cleft Lip/Palate	□ Y	□ N	Rheumatic Fever
□ Y	□ N	Cystic Fibrosis	□ Y	□ N	Seizures/Seizure Disorder
□ Y	□ N	Developmental Delay	□ Y	□ N	Sickle Cell □ Anemia □Trait
□ Y	□ N	Diabetes	□ Y	□ N	Speech Delay
□ Y	□ N	Eating Disorder	□ Y	□ N	Thyroid Disease
□ Y	□ N	Emotional/Behavioral Psych Issue	□ Y	□ N	Tuberculosis
□ Y	□ N	Hearing Problems	□ Y	□ N	Up to date with immunizations

Does the patient have any disease, condition or other health problem not listed above? □ Y □ N
If so, please list:

Is the patient currently taking any medications? □ Y □ N
If so, please list:

Has the patient ever been hospitalized since birth or had surgery? □ Y □ N
If yes, why?

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed:

□ None

Dental History			
Date of patient's last visit:	For what service:		
Were x-rays taken?	Name of Dentist:		
Has the patient had any unhappy dental experiences? What is your child's attitude toward dentistry?		□ Y	□ N
Any injuries to mouth/teeth/head?		□ Y	□ N
Any mouth habits: thumb sucking, nail biting, mouth breathing, nursing, bottle, pacifier?		□ Y	□ N
Does the patient brush daily □ Y □ N Number of times a day_____ Does the patient floss daily		□ Y	□ N
Any additional information that you may think is valuable to us?			

To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the Oconomowoc Pediatric Dentistry of any changes.

*Typed name/signature of legal guardian_____ Date_____

*Typed name above constitutes my digital signature