Health History

Child's Name _____ M/F ____/____/____
First Last Birth date

Child's Social Security Number ____/____/____ School Name _____

Has your child ever had any of the following? Please check yes or no.

If you answer yes to any of the questions below please explain on the space provided.

	NO	YES		NO	YES
Heart trouble (including murmur, valve prosthesis)	____	____	Surgical implants or artificial joints	____	____
Hepatitis A, B, C, or D	____	____	Seizures or epilepsy	____	____
Blood disorder/anemia	____	____	Diabetes	____	____
Surgery within past 5 year's	____	____	Tuberculosis / TB	____	____
Kidney disease or trouble	____	____	Cancer	____	____
Allergy to latex	____	____	Mental condition or disorder	____	____
Allergy to medication	____	____			

If yes to any questions please explain: _____

_____

_____

Does your child have any disease, condition, or problem not listed above that you think we should know about?

_____

Is your child being treated by a doctor for any reason? Yes No

If yes, please explain._____

Who is your child's doctor?_____ (____)_____
Name Phone

Is your child taking any medication? (Be sure to include vitamins) _____

_____

Has your child ever been in the hospital? Yes No

If yes, what for?_____

Is this your child's first dental visit? Yes No

Do you have any dental concerns?_____

Does your child drink fluoridated water? Yes No Does your child drink water from a well? Yes No

Who should we contact in case of an emergency? _____ (____)_____
Name Phone

Signature of parent/guardian _____ Date ____/____/____

Signature of Provider _____ Date ____/____/____

For office use only

R: _____

ID#_____