HEALTH HISTORY FORM **PATIENT NAME _____** **DOB _____**

*Your answers to the following questions will help us to understand your child's medical history. If there is a **YES** response, please provide details in the space provided. Please complete **BOTH SIDES** of this form. Thank you for helping us provide the best and most appropriate care for your child.*

Is your child being treated by a physician?	NO	YES	
Is your child taking medication?	NO	YES	
Is your child taking supplements?	NO	YES	
Does your child have allergies?	NO	YES	
Has your child had an adverse or unusual reaction to medication?	NO	YES	
Has your child ever experienced a significant injury?	NO	YES	
Has your child ever been hospitalized?	NO	YES	
Does your child have a history of infections?	NO	YES	
Has your child ever had a blood transfusion?	NO	YES	
Has your child been seen or treated by a dentist?	NO	YES	Dr. _____ Approximate Date
Has your child ever had dental x-rays taken?	NO	YES	Dr. _____ Approximate Date
Has your child stopped breast or bottle feeding?	NO	YES	Age?
Are your child's teeth brushed at least one time per day?	NO	YES	Time(s) of day?
Are your child's teeth flossed one time per day?	NO	YES	
Do you use toothpaste when cleaning your child's teeth?	NO	YES	
Has your child received fluoride in any form?	NO	YES	
Has your child ever had problems with the jaw joints?	NO	YES	
Does or did your child have a digit or pacifier habit?	NO	YES	When discontinued?
Does your child use alcohol, cannabis or tobacco products?	NO	YES	

ORGANS AND REVIEW OF SYSTEMS

□ My child has never been treated for any of the following.

Cardiovascular/Heart	NO	YES	Liver	NO	YES
Respiratory/Lungs	NO	YES	Endocrine glands	NO	YES
Nervous system	NO	YES	Blood/Bleeding	NO	YES
Eyes, ears, nose, throat	NO	YES	Muscles	NO	YES
Tonsils/adenoids	NO	YES	Bones	NO	YES
Stomach/GI	NO	YES	Skin	NO	YES
Kidney/bladder	NO	YES			

ILLNESS

ADD/ADHD	NO	YES	Cleft lip/palate	NO	YES	Leukemia- type _____	NO	YES
AIDS/HIV	NO	YES	Congenital birth defect	NO	YES	Learning Disability	NO	YES
Anemia	NO	YES	Developmental Delay	NO	YES	Mouth Breathing	NO	YES
Allergy	NO	YES	Diabetes	NO	YES	Nutritional Deficiency	NO	YES
Arthritis	NO	YES	Eating disorder	NO	YES	Orthopedic problems	NO	YES
Autism	NO	YES	Fainting	NO	YES	Pneumonia	NO	YES
Behavior Problems	NO	YES	Hearing loss	NO	YES	Pregnancy	NO	YES
Bleeding Disorder	NO	YES	Headaches	NO	YES	Psychiatric disorder	NO	YES
Brain Injury	NO	YES	Heart defect/disease/murmur	NO	YES	Reflux	NO	YES
Bronchitis	NO	YES	Hemophilia	NO	YES	Rheumatic fever	NO	YES
Cancer/Tumor	NO	YES	Hepatitis – type _____	NO	YES	Scoliosis	NO	YES
Cerebral Palsy	NO	YES	Jaundice	NO	YES	Seizures	NO	YES

Sickle cell anemia	NO	YES	Sore throats – frequent	NO	YES	Tetanus	NO	YES
Sinus problems	NO	YES	Spina bifida	NO	YES	Tuberculosis	NO	YES
Snoring/Sleep Apnea	NO	YES	Syndrome	NO	YES	Vision impairment	NO	YES
OTHER								

Which best describes your child's temperament?

□ Easy	Adaptable, regular eating and sleeping habits, calm, not easily upset
□ Difficult	Fussy, irregular eating and sleeping habits, fearful of new situations, upset by noise/stimulation
□ Slow to warm up	May withdraw in new situations but become more positive with repeated exposure

Is there anything else you think we should know about your child?

I authorize the dental team to perform the necessary dental services for my minor/child. I understand that I am financially responsible for all fees, regardless of any insurance coverage in place. I certify that if my child has insurance coverage, I assign, directly, to EPDG all insurance benefits, if any, otherwise payable to me for services rendered. I, hereby, authorize EPDG to release all information necessary to secure the payment of these benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____

Signature of person completing form Relationship or patient Date

_____

TEAM MEMBER REVIEWING HISTORY