

# Child Health History Form

## ABOUT YOUR CHILD

Child's Full Name:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date (MM/DD/YYYY): \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Age: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

\_\_\_\_\_

Referred To This Office By:

Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## DENTAL HISTORY

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

Any injuries to the teeth or jaws? Yes No If Yes, when: \_\_\_\_\_

Does Your Child Receive:  Flouride in Vitamins  Flouridated Water  Gummy Vitamins  
 Flouride Tabs/Drops  None

Has your child experienced any unfavorable reaction from previous medical or dental care? Yes No

If yes, explain: \_\_\_\_\_

How do you think your child will act towards the dentist? \_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

Child's Physician/Pediatrician's Name: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

Is your child presently under the care of a specialist for any medical reason? Yes No

Does your child have a history of health problems? Yes No

If yes, what: \_\_\_\_\_

**Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason?** Yes No

If yes, what: \_\_\_\_\_

**Is your child presently taking any medications?** Yes No

If yes, what: \_\_\_\_\_

**Has your child had a history of taking frequent medications?** Yes No

If yes, explain: \_\_\_\_\_

**Has your child been hospitalized or had surgery?** Yes No

If yes, explain: \_\_\_\_\_

**Is your child allergic to any drugs?** Yes No

If yes, what: \_\_\_\_\_

**Is your child allergic to any foods?** Yes No

If yes, what: \_\_\_\_\_

**Is your child allergic to any medications or dyes?** Yes No

If yes, what: \_\_\_\_\_

**Is your child allergic to any environmental pollutants?** Yes No

If yes, what: \_\_\_\_\_

**Is your child allergic to any latex, metals, or acrylics?** Yes No

If yes, what: \_\_\_\_\_

**Has any family member, including your child had a problem with general anesthetic?** Yes No

If yes, explain: \_\_\_\_\_

**Has your child ever been diagnosed as having any of the following conditions?**

**ADD/ADHD?** Yes No    **AIDS/HIV?** Yes No    **Anemia?** Yes No    **Arthritis?** Yes No

**Asthma?** Yes No    **Autism?** Yes No    **Birth Defects?** Yes No    **Brain Injury?** Yes No

**Bladder Conditions?** Yes No    **Blood Disease?** Yes No    **Blood Transfusions?** Yes No

**Bone or Joint Problems?** Yes No    **Bruising Easily?** Yes No    **Cancer or Malignancies?** Yes No

**Cerebral palsy?** Yes No    **Chemotherapy/Radiation?** Yes No    **Child Abuse?** Yes No

**Chronic Adenoid/Tonsil Infections?** Yes No    **Chronic Ear Infections?** Yes No

**Cleft Lip/Palate?** Yes No    **Congenital Heart Lesion?** Yes No    **Convulsions/Seizures?** Yes No

**Developmentally Delayed?** Yes No    **Diabetes?** Yes No    **Drug Addiction?** Yes No

**Ear Stuffiness, Itching, or Noises?** Yes No    **Emotional Disturbance?** Yes No  
**Epilepsy?** Yes No    **Eye Problems?** Yes No    **Excessive Bleeding Problem?** Yes No  
**Excessive Gagging?** Yes No    **Fainting or Dizziness?** Yes No    **Fever Blisters?** Yes No  
**Growth/Developmental Problems?** Yes No    **Heart Surgery?** Yes No    **Headaches?** Yes No  
**Hearing/Speech Impairments?** Yes No    **Heart Murmur/Defects?** Yes No  
**Hemophilia?** Yes No    **Hepatitis/Liver Disease?** Yes No    **High Blood Pressure?** Yes No  
**Kidney Disease?** Yes No    **Leukemia?** Yes No    **Mental Disability?** Yes No  
**Mouth Sores?** Yes No    **Nutritional Deficiency?** Yes No    **Orthopedic Problems?** Yes No  
**Pain in Jaw Joints?** Yes No    **Premature Birth?** Yes No    **Psychiatric Care?** Yes No  
**Rheumatic Fever?** Yes No    **Scoliosis?** Yes No    **Sickle Cell Anemia?** Yes No  
**Tuberculosis?** Yes No    **Syndrome?** Yes No  
**Other?** Yes No    **If yes, explain:** \_\_\_\_\_  
**Do you wish to talk to the doctor privately about a special concern?** \_\_\_\_\_  
 \_\_\_\_\_

### RESPONSIBLE PARTY (PARENT/GUARDIAN)

**Parent/Guardian Full Name:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Date of Birth (MM/DD/YYYY):** \_\_\_\_\_ **Social Security:** \_\_\_\_\_

**Address:**

Street Address: \_\_\_\_\_

Street Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Business Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Parent/Guardian Full Name:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Date of Birth (MM/DD/YYYY):** \_\_\_\_\_ **Social Security:** \_\_\_\_\_

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Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is patient living with both parents/guardians? Yes No

**Siblings:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Primary Dental Insurance: \_\_\_\_\_ Group No. : \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Secondary Dental Insurance: \_\_\_\_\_ Group No. : \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I am the (parent/guardian) of the child listed above who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Growing Smiles. This includes exposure of radiographs as necessary, use of local anesthesia, inhalation and oral medication, responsible restraint as needed, and use of appropriate medicaments and materials for such treatment. If I have any objections to certain aspects of treatment. I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# Infant Health History Form

## PATIENT INFORMATION

Patient's Name:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date (MM/DD/YYYY): \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Birth Hospital: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Present Weight: \_\_\_\_\_ Vaginal Birth? Yes No C-Section Birth? Yes No

Any Birth Complications? Yes No If Yes, please explain: \_\_\_\_\_

## MEDICAL HISTORY

Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life.

Did your child receive the Vitamin K shot? Yes No

Was your infant premature? Yes No If Yes, how many weeks? \_\_\_\_\_

Does your infant have heart disease? Yes No If Yes, please explain: \_\_\_\_\_

Has your infant had any surgery? Yes No If Yes, please explain: \_\_\_\_\_

Are you presently breastfeeding? Yes No If no, how long since you stopped? \_\_\_\_\_

Bleeding Disorder? Yes No If Yes, please explain: \_\_\_\_\_

**Has your infant experienced any of the following? Please check and elaborate as needed.**

Poor latch at breast at bottle? Yes No If Yes, please explain: \_\_\_\_\_

Falls asleep while eating? Yes No If Yes, please explain: \_\_\_\_\_

Slides off the nipple when attempting to latch? Yes No If Yes, please explain: \_\_\_\_\_

Colic Symptoms? Yes No If Yes, please explain: \_\_\_\_\_

Reflux Symptoms? Yes No If Yes, please explain: \_\_\_\_\_

Clicking or smacking noises when eating? Yes No If Yes, please explain: \_\_\_\_\_

Gagging or choking when eating? Yes No If Yes, please explain: \_\_\_\_\_

Gassy(toots a lot)/Fussy often? Yes No If Yes, please explain: \_\_\_\_\_

Poor weight gain? Yes No If Yes, please explain: \_\_\_\_\_

Gumming or chewing your nipple when nursing? Yes No

If Yes, please explain: \_\_\_\_\_

Pacifier falls out easily, or after a few minutes? Yes No If Yes, please explain: \_\_\_\_\_

Milk dribbles out of mouth when nursing/bottle? Yes No If Yes, please explain: \_\_\_\_\_

Short sleeping requiring feedings every 1-2 hours? Yes No If Yes, please explain: \_\_\_\_\_

Snoring, noisy breathing or mouth breathing? Yes No If Yes, please explain: \_\_\_\_\_

Feels like a full time job just to feed baby? Yes No If Yes, please explain: \_\_\_\_\_

Nose congested often? Yes No If Yes, please explain: \_\_\_\_\_

Baby is frustrated at the breast or bottle? Yes No If Yes, please explain: \_\_\_\_\_

Spits up often? Yes No If Yes, please explain: \_\_\_\_\_

Is your infant taking any medications? Yes No If Yes, please explain: \_\_\_\_\_

Has your infant had a prior surgery to correct the tongue or lip tie? Yes No  
If Yes, please explain: \_\_\_\_\_

How long does it take baby to eat? \_\_\_\_\_

How often does baby eat? \_\_\_\_\_

**Do you have any of the following signs or symptoms? Please check and elaborate as needed:**

Creased, flattened or blanched nipples? Yes No Lipstick shaped nipples? Yes No

Plugged ducts/engorgement/mastitis? Yes No Infected nipples or breasts? Yes No

Blistered or cut nipples? Yes No Nipple thrush? Yes No Bleeding nipples? Yes No

Poor or incomplete breast drainage? Yes No Using a nipple shield? Yes No

One side hurts worse? Yes No If Yes, please explain: \_\_\_\_\_

Pain when first latching (1-10): \_\_\_\_\_ Pain during nursing (1-10): \_\_\_\_\_

**PEDIATRICIAN INFORMATION**

Pediatrician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Lactation Consultant: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Who referred you to our office: \_\_\_\_\_

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