



FAMILY DENTISTRY

DR. MILES NEFF, DDS

Child's Health History

Child's Name: _____ Nickname: _____ Sex: _____

Age: _____ Birthday: _____ Place of Birth: _____

School: _____ Grade: _____

Explain briefly why you brought your child in for dental care: _____

Child's History- In order to render the best possible care and treatment for your child, your assistance is needed in answering the following questions.

1. Does your child have a health problem? _____ If so what? _____

2. Does your child have any limiting mental or emotional problems? _____

3. What is the most serious illness your child has ever had? _____

4. Who is your child's physician? _____, when was your child's last physical examination? _____

5. Has your child ever been hospitalized? _____ When & why? _____

6. Does your child have or has your child ever had any of the following:

☐ Heart Trouble

☐ Allergies

☐ Diabetes

☐ Asthma

☐ Epilepsy

☐ Tuberculosis

☐ Anemia

☐ Nervousness

☐ Rheumatic Fever

☐ Kidney Problems

☐ Liver Problems

☐ Bleeding Disorders

7. Has your child ever experienced any unfavorable reactions to any medicine? Such as penicillin, aspirin, or local anesthetic? _____

8. Is your child taking any medication now? _____ If yes, what? _____

9. Has your child had any unfavorable reactions to medical or dental care? _____

10. Is this your child's first visit to the dentist? _____

11. Is your child receiving daily fluoride at the present time? _____

12. Does your child have a toothache now? _____ Has your child ever had one? _____

13. Is there anything that we should know about your child before beginning a dental examination?

14. Are there any questions you have regarding your child's dental development or care? _____

Child's Name: _____

Signature: _____ Relationship: _____ Date: _____