CHARLES HENDERSON CHILD HEALTH CENTER
P. O. Box 928
TROY, ALABAMA 36081
(334) 566-7600

Patient Evaluation

PATIENT NAME _____ Date of Birth _____ Sex _____ Race _____

Chart Number _____ Home Telephone _____ Work Telephone _____

DENTAL

	YES	NO	
1.	( )	( )	Has your child ever been seen by a dentist?
2.	( )	( )	Will your child be a cooperative dental patient?
3.	( )	( )	Does your child suck fingers or thumb or have a similar habit?
4.	( )	( )	Does your child participate in sports activities?

5. Please check if your child has (had):

Toothache	( )	Teeth bumped	( )	Bleeding gums	( )
Sensitive Teeth	( )	Discolored Teeth	( )	Other	( )

6.	( )	( )	Is your community water supply fluoridated?
7.	( )	( )	Have you ever given your child vitamins or tablets with fluoride?
8.	( )	( )	Do you supervise your child's tooth brushing procedure?
9.	( )	( )	Does your child use a dental floss?

What type of toothpaste does your child use? _____

Is there additional information we should be aware of prior to providing dental care for your child?

_____

HEALTH

10.	( )	( )	Is your child presently being treated by your physician?
11.	( )	( )	Has your child ever been a patient in a hospital?
12.	( )	( )	Has your child ever been a patient in an emergency room?
13.	( )	( )	Does your child have any allergies? _____
14.	( )	( )	Is your child presently taking any medications? _____
15.	( )	( )	Is your child presently immunized (protected) against?

Diphtheria, Whooping Cough & Tetanus, Polio, Measles & German Measles (Rubella)

16. When was your child's last physical examination? Date _____

Reason _____

17. Place a check if your child has (had) problems with the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Heart	( )	( )	Liver	( )	( )	Muscles	( )	( )	Speech	( )	( )
Heart Murmer	( )	( )	Hepatitis	( )	( )	Asthma	( )	( )	Emotions	( )	( )
Rheumatic Fever	( )	( )	Kidney	( )	( )	Epilepsy	( )	( )	Other	( )	( )
Bleeding	( )	( )	Bones	( )	( )	Diabetes	( )	( )			

ELABORATION _____

_____

_____

Periodic Update _____

Periodic Update _____

Date _____ Dentist _____

Date _____ Parent _____