NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
CHILD DENTAL HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Today's Date: _____

Please answer ALL of the following questions:

Yes	No	
☐	☐	Is this child under treatment by a physician?
☐	☐	Is this child taking any medicine now? Please list on next page.
☐	☐	Has this child ever been seriously sick or hospitalized? If so, please provide details _____
☐	☐	Have you ever been told by a physician that this child has a heart murmur?
☐	☐	Does this child have asthma or hay fever? (Underline which condition)
☐	☐	Does this child have hives or skin rash? (Underline which condition)
☐	☐	Is this child physically or mentally handicapped?
☐	☐	Does this child have any emotional or developmental issues (such as ADHD, autism)? If so, please provide details _____

Has this child ever had any history of the following?

Yes	No	
☐	☐	Rheumatic Fever
☐	☐	Rheumatoid Arthritis
☐	☐	Jaundice (yellow skin & eyes)
☐	☐	Hepatitis
☐	☐	Diabetes
☐	☐	Tuberculosis (TB)
☐	☐	Scarlet Fever
☐	☐	Heart Trouble
☐	☐	Kidney or Liver Involvement
☐	☐	Convulsions or Epilepsy
☐	☐	Bleeding Disorders
☐	☐	Measles

ALLERGIES: Has this child ever experienced an allergic or bad reaction to:

Yes	No	
☐	☐	Aspirin
☐	☐	Penicillin
☐	☐	Sulfa Drugs (Sulfonamides)
☐	☐	Dental Anesthetics (Novacaine)
☐	☐	Codeine
☐	☐	Nitrous Oxide Analgesia (laughing gas)
☐	☐	Tranquilizers (Valium, Vistaril, Atarax)
☐	☐	Other Medicines (specify):

_____

Yes	No	
☐	☐	Does child bleed for a long time when he cuts himself?
☐	☐	Is this the first dental visit for this child? (If "no" give approximate date of last dental visit _____)
☐	☐	Has child had any difficulty accepting dental treatments previously?
☐	☐	Do you anticipate child having difficulty accepting dental treatment?

Fluoride and hygiene history:

Yes	No	
☐	☐	Does your child use fluoridated drinking water?
☐	☐	Does your family use a fluoridated toothpaste?
☐	☐	Has your child had previous topical fluoride applications? If so, when? _____
☐	☐	Has your child ever taken any fluoride drops or vitamins? If so, when? _____
☐	☐	Do you brush your child's teeth?
☐	☐	Do your child's gums bleed when brushing?

Female patients ONLY:

Yes	No	
☐	☐	Do you know if this child is pregnant? If so, please give due date_____

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List all prescription and non-prescription drugs (including aspirin) that your child is currently taking or has taken recently:

1. _____ 3. _____
2. _____ 4. _____

Is there anything else about your child's health we should know? _____

_____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If my child's health or medications change, I will inform clinic personnel at my next appointment.

Patient or Legal Guardian's Signature _____

Relationship to Patient _____ Date _____

Witness Signature _____ Date _____

HEALTH HISTORY COMMENTS & UPDATES (TO BE COMPLETED BY CLINICIAN)

_____

_____

_____

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Provider Signature _____ Date _____