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	
1	☐	☐	Is this child under treatment by a physician?
2	☐	☐	Is this child taking any medicine now? Please list on next page.
3	☐	☐	Has this child ever been seriously sick or hospitalized? If so, please provide details _____
4	☐	☐	Have you ever been told by a physician that this child has a heart murmur?
5	☐	☐	Does this child have asthma or hay fever? (Underline which condition)
6	☐	☐	Does this child have hives or skin rash? (Underline which condition)
7	☐	☐	Is this child physically or mentally handicapped?
8	☐	☐	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	
9	☐	☐	Rheumatic fever
10	☐	☐	Rheumatoid arthritis
11	☐	☐	Jaundice (yellow skin & eyes)
12	☐	☐	Hepatitis
13	☐	☐	Diabetes
14	☐	☐	Tuberculosis (TB)
15	☐	☐	Scarlet fever
16	☐	☐	Heart trouble
17	☐	☐	Kidney or liver involvement
18	☐	☐	Convulsions or epilepsy
19	☐	☐	Bleeding disorders
20	☐	☐	Measles

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

	Yes	No	
21	☐	☐	Aspirin
22	☐	☐	Penicillin
23	☐	☐	Sulfa drugs (Sulfonamides)
24	☐	☐	Dental anesthetics (Novacaine)
25	☐	☐	Codeine
26	☐	☐	Nitrous oxide analgesia (laughing gas)
27	☐	☐	Tranquilizers (Valium, Vistaril, Atarax)
28	☐	☐	Other medicines (specify): _____

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

Fluoride and hygiene history:

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

Female patients ONLY:

	Yes	No	
39	☐	☐	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 have taken recently:

DRUG NAME	DOSAGE	FREQUENCY

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 Signature: _____

Relationship to Patient: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

OFFICE USE ONLY

Health History Comments & Updates

_____

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PROVIDER Signature: _____ **Date:** _____