HEALTH HISTORY QUESTIONNAIRE

Email:

Patient Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Address: **City:** **State:** **Zip Code:**	
Home Phone: **Cell Phone:**	**Reason for today's visit:** ☐6Month ☐Pain☐ Other_____

PATIENT HEALTH HISTORY

Childhood illness:
Please Answer the Following Questions for Patient: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐Rheumatic Fever ☐ Polio ☐ Jaundice

Please check any that currently apply

☐ ADD ☐ ADHD	☐ Bleeds Easily	☐ Diabetes Type_____
☐ Autism	☐ Hay Fever	☐ Leukemia / Cancer
☐ Allergies to_____	☐ Genetic Disorder	☐ Tuberculosis
☐ Anemia	☐ Heart Disease	☐ Hepatitis A
☐ Asthma	☐ Heart murmur	☐ Hepatitis B
☐ Developmental Delays	☐ Rheumatic Fever	☐ Hepatitis C
☐ Down Syndrome	☐ Cystic Fibrosis	☐ HIV/AIDS
☐ Speech Delays	☐ Snoring	☐ Kidney Disease
☐ Respiratory Problems	☐ Epilepsy / Seizures	☐ Blind
☐ Tuberculosis	☐ Joint Replacement	☐ Pregnant
☐ Hearing Problems	☐ Liver Disease	☐ OTHER_____
☐ Low Blood Pressure	☐ High Blood Pressure	☐ **NONE OF THE ABOVE (PARENT INITALS)** _____

Health History
Is the patient currently taking any medications? ☐ Yes ☐ No

If yes please list all medications including over the counter Medication being taken _____

Does the patient have any allergies? ☐ Yes ☐ No If yes please explain_____

Has the patient been hospitalized in the last 5 years? ☐ Yes ☐ No If yes please explain_____

Patient Dental Health History

Has the patient ever had and unhappy dental experience? ☐ Yes ☐ No

Dose the patient floss daily? ☐ Yes ☐ No

Does the patient have any habits such as mouth breathing sleeping with a bottle or zippy cup or thumb sucking? ☐ Yes ☐ No

Does the patient brush daily? ☐ Yes ☐ No

Do the gums bleed while flossing or brushing? ☐ Yes ☐ No

Is the patient exercising any pain? ☐ Yes ☐ No

Is the patients' teeth sensitive to hot or cold Liquids or foods? ☐ Yes ☐ No

Has the patient ever had and unhappy dental experience? ☐ Yes ☐ No

Does the patient have any sores or lumps in mouth? ☐ Yes ☐ No

Does the Patient clench or grind their teeth? ☐ Yes ☐ No

Has the patient ever suffered any trauma to the face, mouth, or jaw? ☐ Yes ☐ No

Has the patient ever had braces? ☐ Yes ☐ No

Last time patient had a dental exam Date:_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical/dental record.

I certify that I have read and understand the above information to the best of my knowledge; the above questions have been answered accurately. I understand the providing false or incorrect information can be dangerous to my child's health.

Parent/Guardian Name_____ Parent/Guardian Signature_____

Dentist Signature_____ Date_____