HEALTH HISTORY UPDATE

Setzer, Cochran & Soares
Pediatric Dentistry

Child's Name: _____ Date: _____

Father's Full Name: _____ Mother's Full Name: _____

Home Ph #: _____ Cell Ph #: _____ OK to text? Y/N Work Ph #: _____

Address: _____

Email address for confirmations: _____

1. Is there anything about your child's teeth, mouth or jaw that concerns you? Y/N _____

Do you have any concerns about today's appointment that you'd like brought to your doctor's attention?

_____

2. Is your child presently under the care of a physician for any medical reasons? Y/N If so, for what?

_____

3. Is your child taking any medications? Y/N _____

4. Does your child have a medical condition? (heart murmur, heart defect, etc.) that requires antibiotics before dental treatment? Y/N _____

If so, has your child taken the prescribed medication? What? _____ Dosage? _____ When? _____

5. Is your child allergic to a medicine or other product? Y/N What? _____

6. Is your child allergic to vinyl, metals or other product? Y/N _____

7. Is your child allergic to latex (balloons or other products)? Y/N _____

8. Are you on well water? _____ Do you use bottled water? Y/N What brand? _____

9. Are you interested in information on athletic mouth guards? _____

Signature of parent or guardian: _____