Cochran, Soares, and Associates
Pediatric Dentistry

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*All are Diplomats of the American Board of Pediatric Dentistry

HEALTH HISTORY UPDATE

Patient Name(s): _____ Date: _____

Patient Sex: _____ Patient Age: _____

Parent/Guardian Name(s): _____

Cell Phone: _____ OK to text? ☐ Yes ☐ No Work Phone: _____

Address: _____

Email Address: _____

1. Is there anything about your child's teeth, mouth or jaw that concerns you? ☐ Yes ☐ No

_____

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

☐ Yes ☐ No _____

3. Is your child presently under the care of a physician for any medical reasons? ☐ Yes ☐ No

If so, for what? _____

4. Is your child taking any medications? ☐ Yes ☐ No _____

5. Does your child have a medical condition (heart murmur, heart defect, etc.) that requires antibiotics before dental treatment? ☐ Yes ☐ No If so, has your child taken the prescribed medication? ☐ Yes ☐ No

What? _____ Dosage? _____ When? _____

6. Is your child allergic to a medicine or other product? ☐ Yes ☐ No _____

7. Is your child allergic to vinyl, metals or other product? ☐ Yes ☐ No _____

8. Is your child allergic to latex (balloons or other products)? ☐ Yes ☐ No

9. Are you on well water? ☐ Yes ☐ No Do you drink bottled water? ☐ Yes ☐ No

What brand of bottled water? _____

10. Are you interested in information for athletic mouth guards? ☐ Yes ☐ No

Signature: _____ Date: _____

PATIENT, PARENT OR GUARDIAN SIGNATURE