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**All are Diplomats of the American Board of Pediatric Dentistry*

HEALTH HISTORY UPDATE

Patient Name(s): Date of Birth:

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