Child History Form(Copy)

Patient Name: Birth Date: Date Created:

Parents' Names

Primary Health Care Provider

Is your child taking any medications? ◯ Yes ◯ No If yes

Does your child have any allergies? ◯ Yes ◯ No If yes

Does your child have any of the following?

Heart Problems	◯ Yes ◯ No	Convulsions/Seizures	◯ Yes ◯ No
Lung Problems	◯ Yes ◯ No	Physical Disabilities	◯ Yes ◯ No
Liver Problems/Hepatitis	◯ Yes ◯ No	Intellectual Disabilities	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hemophilia/Bleeding Disorders	◯ Yes ◯ No
HIV/Aids	◯ Yes ◯ No	Cancer	◯ Yes ◯ No

Does your child have any other health conditions not listed? ◯ Yes ◯ No If yes

Does your child have any harmful dental habits (thumbsucking, pacifier use, etc)? ◯ Yes ◯ No If yes

Does your child receive any fluoride supplements? ◯ Yes ◯ No If yes

Do you have any other concerns regarding your child? ◯ Yes ◯ No If yes

Signature of Parent/Guardian:

X Date:_____