**SECTION 2 – CHILD HEALTH HISTORY**

(Does not need filled out if your child is receiving only Fluoride Varnish)

**Has your child ever had or now have any of the following? If you answer YES, please explain below:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  | YES | NO |  |
|  |  | Heart trouble |  |  | Kidney Disease |  |  | Cancer |
|  |  | Tuberculosis |  |  | Bleeding problems |  |  | Lupus |
|  |  | Hepatitis B |  |  | Sickle Cell Anemia |  |  | TMD/TMJ |
|  |  | Hepatitis (other) |  |  | Skin disease |  |  | Artificial Joints Pins/Screws |
|  |  | HIV+ |  |  | AIDS |  |  | Other Special Needs |
| **Allergies:** | | | | | | | | |
|  |  | Silver (rare) |  |  | Seasonal |  |  | Medications |
|  |  | Latex |  |  | Other |  |  |  |
| **Heart Problems:** | | | | | | | | |
|  |  | Rheumatic Fever |  |  | Heart Murmur |  |  | Mitral Valve Prolapse |
|  |  | Septic Defect |  |  | Artificial Heart Valve |  |  | Heart Disease |

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Bleeding Disorder |  | Yes |  | No |  |  |  |  |  | | Diabetes |  | Yes |  | No | If yes, is your child insulin dependent? |  | Yes |  | No | | Asthma |  | Yes |  | No | If yes, does your child keep a rescue inhaler with the nurse? |  | Yes |  | No | | | | | | |
| **Special Considerations - Please circle and explain any that apply:** | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Psychiatric |  | Emotional Problems |  | Physical Handicap |  | Developmentally Delayed |  | ADD-ADHD |  | Autism |  | Epilepsy |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Medications - Please list all medications your child is taking and dosage.** | | | | | |
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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Is your child required by a physician to take a pre-medication prior to dental treatment?**  **If yes, for what condition?** |  | Yes |  | No | | | | | |
| **When did your child last visit a dentist? Please circle:** In the past More than a year Never  **Why did your child visit the dentist? Please circle:**  Checkup cleaning mouth pain filling tooth pulled other  **Other Information**: Please tell us anything you think we should know about your child’s health or previous dental experiences that would help us treat your child or meet their specific needs:  **PARENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_** | | | | |