Salem Pediatric Dental & Orthodontic Associates

Health History Form

Patient's full name: ______________________________ Date of birth: ____________

Preferred name (Nickname): ______________________________ Male/Female: ____________

Parents' names: ______________________________

Home address: ______________________________

Employed by: ______________________________ Occupation: ____________

Phone: Home - ____________ Mobile - ____________ Work - ____________

Email address: ______________________________

Names and ages of siblings: ______________________________

____

Who can we thank for referring you to our practice? ______________________________

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1.	Yes	No	Is the patient in good general health?
2.	Yes	No	Has there been a change in the patient's health within the past year?
3.	Yes	No	Has the patient been hospitalized or had a serious illness in the last three years? If YES, why? ____________
4.	Yes	No	Is the patient being treated by a physician now? For what? ____________
5.	Yes	No	Is the patient in pain now?

II. WHICH OF THE FOLLOWING DOES THE PATIENT HAVE:

6.	Yes	No	Heart disease	18.	Yes	No	Arthritis
7.	Yes	No	Heart defect	19.	Yes	No	Eye/vision problem
8.	Yes	No	Heart murmur	20.	Yes	No	Ear/hearing problem
9.	Yes	No	Rheumatic fever	21.	Yes	No	Skin disease
10.	Yes	No	Asthma, TB or other lung disease	22.	Yes	No	Herpes
11.	Yes	No	Hepatitis or other liver disease	23.	Yes	No	Kidney or bladder disease
12.	Yes	No	Stomach or intestinal problem	24.	Yes	No	Thyroid or adrenal disease
13.	Yes	No	Diabetes	25.	Yes	No	Bleeding disorder
14.	Yes	No	Epilepsy	26.	Yes	No	Autism or other pervasive developmental disorder
15.	Yes	No	HIV/AIDS				
16.	Yes	No	Genetic disorder	27.	Yes	No	Psychiatric or behavioral disorder
17.	Yes	No	Tumors or cancer	28.	Yes	No	Other (not listed above)

III. ADDITIONAL INFORMATION:

29.	Yes	No	Is the patient currently taking any medications? Please list: ____________
30.	Yes	No	Does the patient have allergies to any medication? Which one(s)? ____________
31.	Yes	No	Does the patient have any other allergies? To what? ____________
32.	Yes	No	Does the patient use tobacco in any form?
33.	Yes	No	Does the patient use recreational drugs in any form?
34.	Yes	No	Does the patient take birth control pills?

IV. DENTAL HISTORY:

35. What is the reason for today's visit? ____________
36. Has the patient ever been treated by a dentist before? ____________
37. How did the patient respond to previous dental treatment? ____________
38. When was the last time dental x-rays were taken of this child? ____________
39. Does the patient have any habits which might affect the mouth? ____________
40. Does the patient drink from a bottle? If not, when did he/she stop? ____________
41. Please describe any specific requests or concerns you have regarding the patient's dental care. ____________

V. SIGNATURE:

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in the health of the patient and/or changes in medications.

Signature: ____________ Relationship: ____________ Date: ____________