

**HEALTH HISTORY QUESTIONNAIRE**

Has your child had previous Anesthesia/Sedation or Surgery? YES NO  
If Yes, please list: \_\_\_\_\_ Complications, please list: \_\_\_\_\_  
Does your child take medications? YES NO If Yes, please list (include herbals): \_\_\_\_\_  
Does your child have any Allergies to Medications? YES NO If Yes, please list: \_\_\_\_\_  
Any reaction to local anesthetics (i.e. Novocain) or antibiotics? YES NO If Yes, please list: \_\_\_\_\_

**Please answer the following questions to the best of your ability - HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE ALL THAT APPLY)**

**Respiratory:** Asthma Sleep apnea Snoring Smoking Seasonal allergies Recent cold/flu  
Frequent ear/Tonsil infections Sinus Tuberculosis Other: \_\_\_\_\_

**Cardiovascular:** Murmur Congenital defect Rheumatic Fever High blood pressure Heart Attack  
Angioplasty/Stents Chest Pain Abnormal heart rhythm Other: \_\_\_\_\_

**Liver/Gastrointestinal:** Hepatitis Heartburn Ulcers Hernia Bowel/colon Other: \_\_\_\_\_

**Neurological/Musculoskeletal:** Seizures Developmental disability ADD/ADHD Migraines/Headaches  
Autism Anxiety Depression Stroke Hearing/visual impairment Numbness/Tingling Arthritis  
Back Pain Learning disability Speech Other: \_\_\_\_\_

**Renal/Endocrine:** Diabetes Thyroid Kidney Stones Recent weight loss or gain Other: \_\_\_\_\_

**Hematologic:** Cancer/Chemotherapy HIV Bleeding problems Low blood count

Is your child under the care of a physician for any chronic medical problems? YES NO  
Please list the name of the supervising Physician responsible for your child's care:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**DENTAL HISTORY**

Last visit to a dentist: \_\_\_\_\_ (approximate date) \_\_\_\_\_ (Dentist Name)

**What concerns regarding your child's teeth prompted this visit?**

\_\_\_\_\_ I desire comprehensive dental care for my child.  
\_\_\_\_\_ I have specific dental concerns. My concerns are: \_\_\_\_\_  
\_\_\_\_\_ My child has complained about dental problems.  
\_\_\_\_\_ My child suffered an injury to the head/mouth/teeth.  
If so, explain \_\_\_\_\_

**Has your child had any history of the following habits:**

\_\_\_ Thumb-sucking \_\_\_ Finger-sucking \_\_\_ Lip-biting \_\_\_ Nail Biting \_\_\_ Pacifier  
Are any of these habits currently active? YES NO  
Child's attitude toward dentistry: \_\_\_ Favorable \_\_\_ Unfavorable \_\_\_ Apprehensive

**I understand that the information that I have given is correct to the best of the knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform the office of any changes in my child's medical status. I authorize Drs. Jenkins and LeBlanc and ancillary staff to perform the necessary dental services my child may need.**

\_\_\_\_\_  
(Signature of parent of guardian)

\_\_\_\_\_  
(Date)