CONFIDENTIAL HEALTH HISTORY

ROGERS FAMILY DENTISTRY
8284 Beechmont Ave.
Cincinnati, OH 45255
Telephone: (513) 231-1012

Child's Name_____ Date of Birth_____
Last First Middle

Sex M F Physician_____ Phone_____

Preferred Name_____

Is the child under active treatment at this time? Y N Explain_____

Has the child been hospitalized or had a serious illness? Y N Explain_____

_____

List all allergies _____

List all medications, prescribed or over-the-counter, that the child is currently using _____

_____

Has the child ever had the following medical problems? Place a √ by any that apply.

___ Hepatitis	___ Diabetes	___ Tuberculosis
___ HIV or AIDS	___ Thyroid Disease	___Chronic sinus problems
___ Asthma/ Respiratory	___ Kidney Disease	___Liver Disease
___ Venereal Disease	___ Mental Illness	___ Epilepsy/ Seizures
___ Drug/Alcohol abuse	___ Heart Murmur	___Congenital Heart Defect
___ Rheumatic Fever	___ Hemophilia/Blood disorder	___ Blood Pressure High or Low
___ Ear/ Throat infections	___ Cancer/Type_____	___Steroid drug treatment
___ Hearing impaired	___ Visually impaired	

Please list any other health problems_____

_____

Does the child have any disabilities? Y N Explain_____

PLEASE COMPLETE BACK SIDE

Check any of the following to which the child has had an allergic or adverse reaction.

___ Aspirin ___ Penicillin ___Erythromycin

___ Pain Medication ___ Codeine ___ Iodine

___ Latex ___Dental Anesthetic ___ General Anesthetic

___ Any other antibiotics ? Please list_____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my child's medical status.

Signature of Parent / Guardian _____Date_____

DENTAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY

___ Currently has a toothache

___ Clenches or grinds teeth

___ Mouth Breathing Day? Night?

___ Parent brushes child's teeth

___ Tobacco use Cigarettes Chewing/Dip

___ Orthodontic referral has been made

___ Sucks: Fingers Thumb Pacifier

___ Parent concerned about bite or spacing

___ Fear of medical or dental situations

___ Parent flosses child's teeth

___ Missing teeth (that you know of)

___ Bad breath

Please list any other dental concerns you may have._____

OFFICE USE ONLY

Date_____Comments_____Initial_____

Date_____Comments_____Initial_____

Date_____Comments_____Initial_____

Date_____Comments_____Initial_____

Date_____Comments_____Initial_____

Date_____Comments_____Initial_____