EASTSHORE PEDIATRIC DENTAL GROUP
TERI L. KIM, DDS THEA S. DOSANJH, DDS

Child's name: _____ **Health History Form**

Pediatrician: _____ Phone:_____ Date of last physical: _____

(Y) (N) Does your child see a doctor for anything beyond routine check-ups? If yes, reason? _____

(Y) (N) Has your child seen any medical specialists now or in the past? If yes, why? _____

(Y) (N) Are immunizations up to date? If no, please elaborate _____

(Y) (N) Does your child have any medical issues? If yes, please list: _____

(Y) (N) Does your child have any emotional or psychiatric concerns? If yes, please list: _____

(Y) (N) Have you ever been told your child needs antibiotics before dental treatment? _____

(Y) (N) Has your child been hospitalized or had surgery? If yes, for what?_____

(Y) (N) Does your child take medications, including over the counter and herbal? If so, what? _____

(Y) (N) Has your child ever taken bisphosphonates? If so, why, and when? _____

(Y) (N) Does your child have any allergies or reactions to the following? Please check all below that apply:

___Peanuts/nuts ___Bisulfites ___Latex ___Pollen/Environmental ___ General Anesthesia (or family history of this)

___Eggs ___Metals ___Acrylic ___Sulfa drugs ___Antibiotics (list): _____

___Other allergies (please list): _____

Does your child have a history of any of the following?

ADHD or ADD	Y	N	Cystic Fibrosis	Y	N	Malignant hyperthermia	Y	N
Anemia	Y	N	Delayed Development	Y	N	Murmur	Y	N
Arthritis/Joint disorder	Y	N	Depression or Anxiety	Y	N	Muscular disorder	Y	N
Artificial Joint or Plate	Y	N	Diabetes	Y	N	Premature birth	Y	N
Asthma	Y	N	Down Syndrome	Y	N	Rheumatic Fever/ heart issues	Y	N
Autism Spectrum Disorder	Y	N	Earaches or Infections	Y	N	Seasonal allergies	Y	N
Bladder issues	Y	N	Eating disorder	Y	N	Sleep apnea	Y	N
Bleeding disorder	Y	N	Emotional or School issues	Y	N	Speech disorder	Y	N
Bone disorder	Y	N	Epilepsy or seizures	Y	N	Sinusitis	Y	N
Brain injury	Y	N	Hearing impairment	Y	N	TMJ issues	Y	N
Bruising	Y	N	HIV or AIDS	Y	N	Tonsils	Y	N
Cancer or Malignancy	Y	N	Hepatitis	Y	N	Tuberculosis	Y	N
Cardiac/Heart disease	Y	N	Immune disorder	Y	N	Vision impairment	Y	N
Cerebral Palsy	Y	N	Kidney issues	Y	N	Other: _____		
Chemotherapy or Radiation	Y	N	Liver issues	Y	N	_____		

Please list any other information that is important for us to know when treating your child: _____

I have filled out this health history form correctly to the best of my knowledge. I understand that for the safety of my child, it is my responsibility to inform the dental team if there are any changes to my child's health.

Signature_____ Relationship: _____ Date: _____