Patient Name: _____

Patient DOB: _____

History History Form - Child

edinadentalcare
COMPREHENSIVE AND AESTHETIC DENTAL CARE

What are the child's pronouns? ☐ she/her ☐ he/him ☐ they/them ☐ other: _____

Have there been any changes in the child's general health in the past year? ☐ Yes ☐ No

If yes, please describe:

Please list their physicians name and clinic:

When were they last seen by their physician?

Is the child currently under a physician's care for a specific problem? ☐ Yes ☐ No

If yes, please explain:

Has the child ever been hospitalized or had a serious illness? ☐ Yes ☐ No

If yes, please describe:

Does the child, or has the child ever had?

- ☐ AIDS/HIV
- ☐ Anxiety
- ☐ Bleeding disorder, anemia, bleeding tendency, blood transfusion
- ☐ Bruising
- ☐ Congential, cardiovascular, or other heart issues/diseases
- ☐ Depression
- ☐ Diabetes (Type 1, Type 2)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Implants placed anywhere in the body
- ☐ Kidney disease or kidney failure, requiring dialysis
- ☐ Frequent or recurring mouth sores
- ☐ Radiation for cancer treatment
- ☐ Liver disease (jaundice, hepatitis A, B, or C)
- ☐ Lung disease (asthema, emphysema, chest pain)
- ☐ Seizures, convulsions, epilesy, fainting, dizziness
- ☐ Sinus or nasal problems
- ☐ Snoring
- ☐ Stomach ulcers or colitis
- ☐ Thyroid problems
- ☐ Tobacco/drug use
- ☐ None of the above

Has the child has cancer, chemotherapy, radiation, or transplant operation? ☐ Yes ☐ No

If yes, please explain:

Does the child have any other disease, condition, or problem not listed that we should know about? ☐ Yes ☐ No

If yes, please explain:

Is the child taking any of the following medications?

- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners)
- ☐ Aspirin or drugs such as Motrin, Aleve, Ibuprofen
- ☐ Insulin or oral anti-diabetic drugs
- ☐ Steroids (cortisone, predisone, etc)
- ☐ Heart drugs
- ☐ Prescription pain medication
- ☐ Anti-anxiety agents, sedative-hypnotics, antidepressants
- ☐ Bisphosphonates, antiangeogenic and/or antiresorptive meds
- ☐ None

If yes, please list medications used and frequency:

Is the child taking any other medications that are not listed above? ☐ Yes ☐ No

If yes, please list medications used and frequency:

Has it been recommended that the child take an antibiotic prior to any dental treatment? ☐ Yes ☐ No

If yes, please explain:

Has the child had an allergic or adverse reaction to any of the following?

- ☐ Aspirin, Motrin, Aleve, or Ibuprofen
- ☐ Codine or other pain medication
- ☐ Latex
- ☐ Penicillin or other antibiotics
- ☐ Other
- ☐ No allergies or allergic reactions to the listed medications

If other, please explain:

Does the child have any other medication allergies not listed above? ☐ Yes ☐ No

If yes, please list:

Has the child or an immediate family member had any problem associated with local anesthesia? ☐ Yes ☐ No

If yes, please explain:

Has the child had any adverse effects from dental treatment? ☐ Yes ☐ No

If yes, please explain:

Is there anything else Edina Dental Care should be aware of regarding the child's overall health?

Emergency Contact Name:

Emergency Contact Phone Number:

Relationship to Patient:

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge the above information is cormplete and correct.

Signature of parent or guardian: Date:

Printed name of parent or guardian:

Signature of Doctor: Date:

Clinical Initials: