Camino Pediatric Dentistry

408-733-2008

caringpediatricdds.com

660 S. Bernardo Ave., Ste 1, Sunnyvale, CA 94087

Health History

Patient's Name ____
(first) (Last)

Birthdate ____________ Boy Girl (please circle)

Patient's Physician ______________________________ Phone ______________

Address ____

Specialist ______________________________ Phone ______________

Is/Has Child:

	Yes ✓	No ✓	if yes:
Any illness now?	❑	❑	Type ______
Receiving any medications or drugs?	❑	❑	List ______
Ever been hospitalized?	❑	❑	Date ______
Ever had surgery?	❑	❑	Date ______
Allergic to any medications?	❑	❑	List ______
Allergic to latex products?	❑	❑	List ______
Are there any other allergies?	❑	❑	List ______

Has/Had any history of:

(please circle)

ADD/ADHD	Y N	Epilepsy/Convulsions	Y N	Liver Disease	Y N
Anemia	Y N	Fainting or Dizziness	Y N	Mental Disorder	Y N
Asthma	Y N	Hearing Problem	Y N	Rheumatic Fever	Y N
Autism	Y N	Heart Problem	Y N	Sleep Apnea	Y N
Bleeding Disorder	Y N	Heart Murmur	Y N	Tuberculosis	Y N
Diabetes	Y N	Hepatitis	Y N	Tumors/Cancer	Y N
Emotional Problem	Y N	HIV/AIDS	Y N	Special Needs/Other: ______	
Eczema	Y N	Kidney Disease	Y N		

Dental History

Reason for this appointment ____

How do you feel about the condition of your child's mouth and teeth? ______________________

Date of last dental visit ____________

For what service? ____

Name of former dentist ______________________________

Has Child:

	Yes ✓	No ✓	if yes:
Complained about dental problems?	❑	❑	______
Had any unhappy dental experiences?	❑	❑	______
Had any injuries to mouth, teeth or head?	❑	❑	______
Had any mouth habits such as thumbsucking nail-biting, mouth breathing, pacifier, etc.?	❑	❑	______
Had adverse reactions to anesthetics?	❑	❑	______
Is fluoride taken in any form?	❑	❑	______

Child's attitude toward dentistry ____

Parent or Guardian Signature ______________________________ **Date** ______________