HEALTH HISTORY

Child's Physician_____ Phone _____

Is child under care of physician now? Yes / No

Is child taking any medicines now? Yes / No

Is there excessive bleeding when cut? Yes / No

Has child ever been in the hospital? Yes / No

Has child ever had surgery? Yes / No

Is child allergic to any medicines? Yes / No

Are there any emotional problems? Yes / No

Has child ever had problems with: **(circle)**

Anemia	Hepatitis
Asthma	HIV
Bladder	Kidney
Cancer	Liver
CP	Rheumatic Fever
Convulsions	Thyroid
Diabetes	Tuberculosis
Epilepsy	Other _____
Heart	None of Above

DENTAL HISTORY

Last Dental Visit: Dentist's Name _____ Date _____

Other dentists seen: _____

_____

Any significant dental trauma or problems? _____

_____

_____

_____

May we request release of your child's medical and dental records for our reference? Yes / No

_____ _____ _____

signature relationship to child date