HEALTH HISTORY

PERSONAL

Child's Full Name: _____ Lives with: _____

Child's Primary Care Physician: _____ Telephone number: _____

Family Dentist: _____ Telephone number: _____

MEDICAL

Has your child had any of the following problems? If so, please mark yes " Y " or no " N "

ADD/ ADHD	**Y / N**	**Heart murmur**	**Y / N**
Autism Spectrum	**Y / N**	**Cancer**	**Y / N**
Allergies to drugs or foods	**Y / N**	**Convulsions or epilepsy**	**Y / N**
Allergies to latex	**Y / N**	**Developmental delays**	**Y / N**
Hemophilia or abnormal bleeding	**Y / N**	**Diabetes**	**Y / N**
High Fevers	**Y / N**	**Ear infections**	**Y / N**
Hospital stays/ surgeries	**Y / N**	**Handicaps or disabilities**	**Y / N**
HIV/ AIDS	**Y / N**	**Heart Defects (congenital)**	**Y / N**
Learning disabilities	**Y / N**	**Asthma or lung problems**	**Y / N**
Trauma to mouth or face	**Y / N**	**General Breathing problems**	**Y / N**
TB (Tuberculosis)	**Y / N**	**Snoring**	**Y / N**
Cerebral Palsy	**Y / N**	**Blood transfusions**	**Y / N**
Hepatitis			

Other: _____

Has your child has any unfavorable reactions to any drugs, antibiotics or anesthesia? Yes (Y) No (N)
If so please explain: _____

Is your child currently taking any medications: Yes (Y) or No (N)
If so, what kind: _____ Frequency: _____ Per:_____

Does your child take supplemental fluoride? Yes (Y) or No (N) If yes, please circle: Tablets Drops Water Vitamins

HABITS

Does your child have any of the following habits? If so, please circle Yes (Y) or No (N).

Pacifier use	Y / N	Nail biting	Y / N
Thumb or finger sucking	Y / N	Biting hard objects	Y / N
Lip sucking or biting	Y / N	Grinding teeth	Y / N
Is your child currently nursing?	Y / N	Other habits	Y / N

CHILD'S DENTAL HISTORY

Has your child seen a pediatric dentist before? Y / N

If yes, please list the location and approximate month/year last visit: _____.
Does your child currently have dental problems: Y / N

If yes, please explain: _____.

Purpose for today's visit is: _____.

AUTHORIZATION

The permission of a parent or legal guardian is necessary for dental treatment of a minor. I hereby grant authority to Dr. Jila Mahajan and her auxiliaries to utilize x-rays, anesthetics, pre-medications, preventative and restorative procedures which may be necessary or advisable in the diagnosis and treatment of my child's dental condition. I understand that I will be consulted prior to any treatment being rendered.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE