



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