Copy of ADA Child Health-Dental History Form

ADA American Dental Association
America's leading advocate for oral health

Patient's First Name
-

Patient's Middle Initial
-

Patient's Last Name
-

Patient's Nickname
-

Patient's Date of Birth
-

Parent's/Guardian's Name
-

Relationship to Patient
-

Parent's/Guardian's Date of Birth
-

Address (PO or mailing address)
-

City
-

State
-

ZIP Code
-

Phone
-

Gender
-

Have you(parent/guardian) or the patient had any of the diseases or problem listed below?

- ☐ Active Tuberculosis
- ☐ Persistent cough greater than a three-week duration
- ☐ Cough that produces blood

If you have selected any of the options above, please stop and reach out to the office.

Has the child had any history of, or conditions related to, any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder
- ☐ Bleeding disorders
- ☐ Bones/Joints
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Sinusitis
- ☐ Diabetes
- ☐ Ear Aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth Problems
- ☐ Hearing
- ☐ Heart
- ☐ Hepatitis
- ☐ HIV +/AIDS
- ☐ Immunizations
- ☐ Kidney
- ☐ Latex allergy
- ☐ Liver
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sickle cell
- ☐ Thyroid
- ☐ Tobacco/Drug Use
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other:

Please list the name and phone number of the child's physician:

Name of Physician
-

Phone
-

Child's History

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?
-

If yes, please list:
-

2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs?
-

If yes, please explain:
-

3. Is the child allergic to anything else, such as certain foods?
-

If yes, please explain:
-

4. How would you describe the child's eating habits?
-

5. Has the child ever had a serious illness?
-

If yes, when:
-

6. Has the child ever been hospitalized?
-

7. Does the child have a history of any other illnesses?
-

If yes, please list:
-

8. Has the child ever received a general anesthetic?
-

9. Does the child have any inherited problems?
-

10. Does the child have any speech difficulties?
-

11. Has the child ever had a blood transfusion?
-

12. Is the child physically, mentally, or emotionally impaired?
-

13. Does the child experience excessive bleeding when cut?
-

14. Is the child currently being treated for any illnesses?
-

15. Is this the child's first visit to a dentist?
-

If not the first visit, what was the date of the last dentist visit? Date:
-

16. Has the child had any problem with dental treatment in the past?
-

17. Has the child ever had dental radiographs (x-rays) exposed?
-

18. Has the child ever suffered any injuries to the mouth, head or teeth?
-

19. Has the child had any problems with the eruption or shedding of teeth?
-

20. Has the child had any orthodontic treatment?
-

21. What type of water does your child drink?

☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water

22. Does the child take fluoride supplements?
-

23. Is fluoride toothpaste used?
-

24. How many times are the child's teeth brushed per day?
-

When are the teeth brushed?
-

25. Does the child suck his/her thumb, fingers or pacifier?
-

26. At what age did the child stop bottle feeding? Age:
-

Breast feeding? Age:
-

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. | certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature (ESign)

Date
-

Date :

For completion by dentist only

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