CHILD HEALTH QUESTIONNAIRE – In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.

CHILD'S NAME:	AGE:	NICKNAME:
MALE / FEMALE	DOB:	IS CHILD ADOPTED? **YES / NO**
FATHER'S NAME:	MOTHER'S NAME:	
FAVORITE PET OR TOY:	PET'S NAME:	
LEGAL GUARDIAN'S NAME:		
CHILD'S PHYSICIAN:	PHONE NUMBER:	

Date of Last Physical Examination: _____ How is your child's general health? _____

Has your child had any serious illnesses? **YES / NO**
If yes, please describe: _____

Has your child ever been hospitalized? **YES / NO**
If yes, for what reason? _____

Is your child receiving any medication at this time? **YES / NO**
If yes, please describe: _____

Has your child ever received a blow or injury to his/her head or teeth? **YES / NO**
If yes, please describe: _____

Has your child ever been treated with X-Ray or radiation therapy? **YES / NO**

Has your child ever had any of the following conditions? **Habits?**

Heart Disease	Y	N	Bleeding Problems	Y	N	Poor Eating Habits	Y	N
Heart Murmur	Y	N	Lung Disease	Y	N	Thumb Sucking	Y	N
Rheumatic Fever	Y	N	Liver Disease	Y	N	Pacifier Use	Y	N
Diabetes	Y	N	Learning Disability	Y	N	Bottle Use	Y	N
Scarlet Fever	Y	N	Mental Retardation	Y	N	Other (please describe):		
Kidney Disease	Y	N	Mononucleosis	Y	N			
Epilepsy	Y	N	Hearing Problems	Y	N			
Asthma	Y	N	TB (Tuberculosis)	Y	N			
Hepatitis	Y	N	Sickle Cell Anemia – DISEASE OR TRAIT	Y	N			
AIDS or HIV	Y	N	Emotional Disturbance	Y	N			

Has your child ever had orthodontic treatment**? YES / NO** – When? _____

Does your child receive fluoride in *(please check)*: _____ Drinking water at home _____ By Prescription

Has your child had any unpleasant dental experiences? **YES / NO**
How can we help? _____ Date of last dental examination: _____

What is the nature of today's visit *(please check)*? _____ Regular Exam _____ Emergency _____ Other
If emergency or other, please state problem: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Parent or Guardian Signature _____ Date _____

Doctor/Staff Signature _____Date _____