Child Health/ Dental History

Rowan College at Burlington County Dental Hygiene Clinic

Patient's Name: Last First Middle | Nickname: | Date of Birth:

Parent's/Guardian's Name: | Relationship to Patient:

Address: P.O. Box or Mailing Address | City: | State: | Zip:

Phone: Home (with area code) Work (with area code) | Patient's Sex: ❑ M ❑ F

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ **Yes** ❑ **No**
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, difficulty with, or diagnosis of any of the following:

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

Physician Name: | Phone (including area code)

Physician Address: | City: | State: | Zip:

Dentist Name: | Phone (including area code)

Dentist Address: | City: | State: | Zip:

Child's History

1. Is the child taking any medications at this time? ❑ Yes ❑ No
   If yes, please list: ______________________________
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? ❑ Yes ❑ No
   If yes, please explain: ______________________________
3. Is the child allergic to anything else, such as certain foods? ❑ Yes ❑ No
   If yes, please explain: ______________________________
4. How would you describe the child's eating habits? ______________________________
5. Has the child ever had a serious illness? ❑ Yes ❑ No
   If yes, when: Please describe: ______________________________
6. Has the child ever been hospitalized? ❑ Yes ❑ No
7. Does the child have a history of any other illnesses? ❑ Yes ❑ No
   If yes, please list: ______________________________
8. Has the child ever received a general anesthetic? ❑ Yes ❑ No
9. Does the child have any inherited problems? ❑ Yes ❑ No
10. Does the child have any speech difficulties? ❑ Yes ❑ No
11. Has the child ever had a blood transfusion? ❑ Yes ❑ No
12. Is the child physically, mentally, or emotionally impaired? ❑ Yes ❑ No
13. Does the child experience excessive bleeding when cut? ❑ Yes ❑ No
14. Is the child currently being treated for any illnesses? ❑ Yes ❑ No
15. Is this the child's first visit to a dentist? ❑ Yes ❑ No
    If not the first visit, when was the date of the last dentist visit: ______________________________
16. Has the child had any problem with dental treatments in the past? ❑ Yes ❑ No
17. Has the child ever had dental radiographs (x-rays) exposed? ❑ Yes ❑ No
18. Has the child ever suffered any injuries to the mouth, head or teeth? ❑ Yes ❑ No
19. Has the child had any problems with the eruption or shedding of teeth? ❑ Yes ❑ No
20. Has the child had any orthodontic treatment? ❑ Yes ❑ No
21. What type of water does your child drink:
    ❑ City water ❑ Well water ❑ Bottled water
22. Does the child take fluoride supplements? ❑ Yes ❑ No
23. Is fluoride toothpaste used? ❑ Yes ❑ No
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? ❑ Yes ❑ No
26. At what age did the child stop bottle feeding? Age: ____________
    Breast feeding? Age: ______________________________

CONTINUED ON REVERSE

NOTE: Both Dental Staff and patient are encouraged to discuss any and all relevant patient issues prior to treatment.

I certify that I have read and understood the above. I acknowledge that my concerns, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold any member of the RCBC dental 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.

I also authorize the doctors, dental hygiene staff and dental hygiene students to perform the necessary dental services that my child may need including, but not limited to, cleanings, fluoride treatment, sealants and X-rays.

My contact phone number (should an emergency arise) is: ______________________________

Parent's/Guardian's Signature	Date:	Reviewed by: Student Signature	Date

FOR COMPLETION BY STUDENT AND/OR INSTRUCTOR

Comments on parent/guardian interview concerning health history ______________________________

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Significant findings from questionnaire or oral interview ______________________________

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Dental management considerations ______________________________

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Signature of Instructor: ______________________________ **Date:**______________

For office use only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia

Reviewed by: ______________________________ Date: ______________