

HEALTH HISTORY UPDATE

Please check here if any changes listed below have occurred since your last appointment

Medical

Address

Employment

Date _____

Child's Name _____ Age _____

Parent's Name _____

Address _____

(City)

(State)

(Zip)

Home Phone _____ Cell Phone _____

Mother's current employer _____ Work Phone _____

Father's current employer _____ Work Phone _____

Email Address _____

To assist us in keeping your child's medical history up to date, would you please answer the following questions:

1. Has your child seen his/her physician since your last visit? Yes _____ No _____

If so, why? _____

2. Has your child's medical history changed since your last visit? Yes _____ No _____

If so, how? _____

3. Is your child taking any medication at this present time? Yes _____ No _____

If so, what and why? _____

4. Any injury to head or neck in the last six months? Yes _____ No _____

If so, what? (ex. front teeth) _____

Cause of injury (ex. car accident, bike, door, etc.) _____

5. Any dental problems developed or developing that you are aware of? Yes _____ No _____

6. Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

Signature