Patient Name: ______________________________

Updated Pediatric Health & Social History

To be updated every year

1) Does the patient have any health problems (past or present)? Yes ❑ No ❑
If yes, explain ______________________________
2) Is the patient currently seeing a physician for any problem? Yes ❑ No ❑
If yes, explain ______________________________
3) Does the patient take any medications? Yes ❑ No ❑
If yes, explain ______________________________
4) Does the patient have any allergy to any food, medicine or materials (e.g. antibiotics, latex)? Yes ❑ No ❑
If yes, explain ______________________________
5) Has the patient ever had a heart murmur, heart defect or rheumatic fever? Yes ❑ No ❑
If yes, explain ______________________________
6) Has the patient ever been injured, hospitalized or received surgery? Yes ❑ No ❑
If yes, explain ______________________________
7) Is the patient pregnant or been pregnant in the past? Yes ❑ No ❑
8) Has the patient ever had a blood transfusion? Yes ❑ No ❑

Has the patient ever had any of the following?

Breathing problems or asthma?	Y / N	Airway, tonsil or adenoid problems?	Y / N
Blood problems such as sickle cell anemia?	Y / N	Easy bleeding on brushing?	Y / N
AIDS or HIV infection?	Y / N	Frequent headaches?	Y / N
Frequent cough or tuberculosis (T.B.)?	Y / N	Hepatitis or liver problems?	Y / N
Stomach, bowel problems or gastric reflux?	Y / N	Diabetes, excessive thirst or urination?	Y / N
Endocrine or hormone problems?	Y / N	Kidney problems?	Y / N
Hives or skin rash?	Y / N	Seizures, dizziness, fainting spells or epilepsy?	Y / N
General anesthesia?	Y / N	Birth defect or disability?	Y / N

1) Does the patient have or had any disease or condition not listed above? Yes ❑ No ❑
If yes, explain ______________________________
2) Does anyone in the immediate family have history of allergies, diabetes, etc.? Yes ❑ No ❑
If yes, explain ______________________________
3) Did the patient have any health problems or illnesses when younger or at birth? Yes ❑ No ❑
If yes, explain ______________________________
4) Does the patient have any emotional, behavior or learning problems (e.g. ADD/ADHD)? Yes ❑ No ❑
If yes, explain ______________________________
5) Has the patient related well to previous treatments? Yes ❑ No ❑
If no, explain ______________________________

Name of Patient's Pediatrician: ______________________________ Date of Last Physical: ______________

To the best of my knowledge, the above information is complete and accurate. Providing incorrect information can be dangerous to my child's health and I will inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered during the period of such dental care to third party payers and/or other health practitioners.

Patient's Name: ______________________ Parent/Guardian's Name: ______________________

Signature: ______________________________ Date: ______________

For Office Use Only: **Reviewed By:**

Provider's Name: ______________________________

Signature: ______________________________ Date: ______________