Virginia H. Ellis, DDS
Dental Corp.
Family and Cosmetic Dentistry

Health History- Child

Name:______________________________**DOB:**_______________**Gender:** **M** **F**

What are your concerns for your child today?

Caries (tooth decay):

Is your child cavity prone?...Y N

Does he/she consume sugary foods regularly? ....Y N

Does he/she consume soda or sports drinks?.............Y N
If so, what type and how often?

Does he/she take gummy or chewable vitamins?.......Y N

Homecare:

How often does your child brush his/her teeth?
________times per day

Does anyone help your child brush his/her teeth?.........Y N

Does anyone help your child floss?................................Y N

Does your child use a **manual** or **electric** toothbrush? (circle)
If electric, what brand?

What type of toothpaste does your child use?

Function/Bite/TMJ:

Has your child had orthodontic treatment?..Y N
If so, when?
Does he/she wear a retainer or headgear?............Y N

Does he/she have discomfort when chewing?........Y N

Does your child's jaw click, pop or make grinding sounds?..Y N

Does he/she have any loose teeth? ....Y N

Does he/she currently or have a history of thumb/finger/pacifier sucking? (circle)

Medical Care:

Is your child currently being treated for any medical conditions?..Y N
If so, what condition; if not listed below:

Is your child taking any medications?..........................Y N
If so, please list:

Does your child have any of the following? Please circle:

Birth Defect Tonsilitis Tuberculosis Ear infection Autism

HIV Rash/hives Cystic Fibrosis Heart murmur Arthritis

ADD/ADHD Kidney/Liver problems Seizures Chicken Pox

Measles Anemia Mumps Thyroid Snoring Apnea

Congenital heart defect Diabetes: Type I /Type II

Headaches/Migraines

OTHER:

Allergies:

Does your child have asthma?...................................Y N

Does he/she use an inhaler?......................................Y N

Does he/she have any food sensitivities? ....Y N
Please list:

Is he/she allergic to any of the following? Please circle:

Latex Aspirin Codeine Tetracycline Valium Metals

Sulfa Drugs Lidocaine/Local anesthetic Nitrous Oxide

Penicillin/Antibiotics Erythromycin Vicodin Percodan

OTHER:

Activities:

Does your child participate in sports?...........................Y N
If so, please list sports:

Does he/she wear a mouth guard.................................Y N

Parent/Guardian Signature:_________________________**Date:**_________________

Dr. Signature:_________________________________**Date:**_________________