Salud
Family Health Centers

Dental Health History

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Male___☐___ /Female___☐___

CHIEF COMPLAINT

Is your child/ward, having any dental problems today? Y_____☐ N_____☐

Please List: _____

History of Present Illness (HPI)

Is your child/ward:

1. In good health? Y_____☐ N_____☐
2. Experiencing persistent swollen glands in his/her neck? Y_____☐ N_____☐

MEDICAL HISTORY

Is your child/ward:

1. Under the care of a physician? Y_____☐ N_____☐
   Name, Town and Phone # of Physician: _____
2. Taking, or have taken in the past, Bisphosphonate Medications (medicine for stronger bones)? Y_____☐ N_____☐
3. Experiencing bleeding abnormalities? Y_____☐ N_____☐
4. Being treated for prosthetic (artificial) heart valves or prosthetic (artificial) joints? Y_____☐ N_____☐
5. Being treated for any condition that requires you to take an antibiotic prior to receiving dental treatment? Y_____☐ N_____☐
6. Has your child/ward, had any problems associated with any previous dental treatment? Y_____☐N_____☐
   Please explain:

Are you aware of, or have ever been told by a physician that your child/ward, have any of the following symptoms and/or conditions.

Please indicate (✓) in the appropriate box.

MEDICAL CONDITION	Yes	No	MEDICAL CONDITION	Yes	No
1. Heart Disease	☐	☐	34. Jaundice	☐	☐
2 Heart Attack	☐	☐	35. Cirrhosis	☐	☐
3. Angina	☐	☐	36. Hepatitis A	☐	☐
4. Stroke	☐	☐	37. Hepatitis B	☐	☐
5. Rheumatic Heart Disease	☐	☐	38. Hepatitis C	☐	☐
6. Endocarditis	☐	☐	39. Autoimmune Disorder	☐	☐
7. Heart Murmur	☐	☐	40. Lupus	☐	☐
8. Pacemaker	☐	☐	41. HIV	☐	☐
9. Hypertension (High Blood Pressure)	☐	☐	42. AIDS	☐	☐
10. Hypotension (Low Blood Pressure)	☐	☐	43. STD (Sexually Transmitted Disease)	☐	☐
11. Chest Pain	☐	☐	44. Chronic Diarrhea	☐	☐
12. Shortness of Breath	☐	☐	45. Heartburn	☐	☐
13. Seasonal Allergies	☐	☐	46. Acid Reflux	☐	☐
14. Sinusitis (Sinus Trouble)	☐	☐	47. Ulcers	☐	☐
15. Asthma	☐	☐	48. Seizures	☐	☐
16. Respiratory Disease	☐	☐	49. Epilepsy	☐	☐
17. Emphysema	☐	☐	50. Syncope (Fainting Spells)	☐	☐
18. COPD	☐	☐	51. Mental Illness	☐	☐
19. **Cystic Fibrosis**	☐	☐	52. Depression	☐	☐
20. Bronchitis	☐	☐	53. Anxiety	☐	☐
21. Chronic Cough	☐	☐	54. ADHD	☐	☐
22. Tuberculosis	☐	☐	**55. Down Syndrome**	☐	☐
23. Clotting Disorders	☐	☐	**56. Autism**	☐	☐
24. Hemophilia	☐	☐	**57. Cerebral Palsy**	☐	☐
25. Sickle Cell Disease/Trait	☐	☐	58. Arthritis	☐	☐
26. Anemia	☐	☐	59. Rheumatoid Arthritis	☐	☐
27. Diabetes	☐	☐	60. Osteoporosis	☐	☐
28. Thyroid Disease	☐	☐	61. Cancer(Tumors or Growths)	☐	☐
29. Hyperthyroidism	☐	☐	62. Menstrual Irregularity	☐	☐
30. Hypothyroidism	☐	☐	63. Do you have any other conditions that we should be aware of?	☐	☐
31. Kidney Disease	☐	☐			
32. Dialysis	☐	☐	**Please List:**		
33. Liver Disease	☐	☐			

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Date of Birth: _____

CURRENT MEDICATIONS

1. Is your child/ward, currently taking any medications? Y☐ N☐
2. Please list all Prescription and non-prescription medicines (with strength and dosing) your child/ward, is currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES/INTOLERANCE

1. Does your child/ward, have any allergies? Y☐ N☐
2. Does your child/ward, allergic to, had a reaction to, or been told not to take the following medications:
   Latex_____ Penicillin_____ Sulfa Rx_____ Codeine_____ Local Anesthetic_____
3. Please list any other allergies:

_____ _____
_____ _____
_____ _____
_____ _____

SURGICAL HISTORY

1. Has your child/ward, had any serious illness or surgery? Y☐ N☐
2. What was the illness or surgery? _____
   _____
3. Has your child/ward, had radiation for a tumor? Y☐ N☐
4. Has your child/ward, had Joint Replacement surgery? Y☐ N☐
   Type: _____
5. Has your child/ward, had Heart Valve Replacement surgery? Y☐ N☐

HOSPITALIZATION HISTORY

1. Has your child/ward, been hospitalized? Y_____ N_____
2. For what? _____
   _____

_____ _____

Parent or Guardian Signature Date

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

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