Noble Community Clinics

Child Health History 12 yrs. and Under:

Patient Name:_____**DOB:**_____

Date of Last Dental Visit: _____

Has the child had any history of, or conditions related to, any of the following? *Please circle yes or no.*

Anemia	Yes/No	Growth Problems	Yes/No
Asthma	Yes/No	Hearing	Yes/No
ADHD	Yes/No	Heart	Yes/No
Autism	Yes/No	Hepatitis	Yes/No
Bladder	Yes/No	Immunizations	Yes/No
Bleeding Disorders	Yes/No	Kidney	Yes/No
Bones/Joints	Yes/No	Latex Allergy	Yes/No
Cancer	Yes/No	Liver	Yes/No
Cerebral Palsy	Yes/No	Rheumatic Fever	Yes/No
Chronic Sinusitis	Yes/No	Seizures	Yes/No
Diabetes	Yes/No	Thyroid	Yes/No
Earaches	Yes/No	Tuberculosis	Yes/No
Epilepsy	Yes/No		
Fainting	Yes/No	Other: _____	

Please list the name and phone number of the child's physician:
Name:_____ Phone:_____

Is the child taking any medications?	Yes/No
Is the child allergic to any medications, peroxide, mint?	Yes/No
Is the child allergic to anything else?	Yes/No
Has the child ever had a serious illness?	Yes/No
If yes, when, please describe: _____	
How would you describe the child's eating habits? _____	

Has the child ever been hospitalized?	Yes/No
Has the child ever received general anesthetic?	Yes/No
Does the child have any inherited concerns?	Yes/No
Does the child have any speech difficulties?	Yes/No
Has the child ever had a blood transfusion?	Yes/No
Is the child physically, mentally, or emotionally impaired?	Yes/No
Does the child experience excessive bleeding when cut?	Yes/No
Has the child experienced any difficulties with dental treatment in the past?	Yes/No
Has the child ever had dental radiographs (x-rays)?	Yes/No
Has the child ever suffered any injuries to the mouth, head or teeth?	Yes/No
Has the child had any difficulties with the eruption or shedding of teeth?	Yes/No
Has the child had any orthodontic treatment?	Yes/No

What type of water does your child drink? (Circle one): City, Well, Bottled, or Filtered Water

Does the child take fluoride supplements?	Yes/No
Is fluoride toothpaste used?	Yes/No
How many times are the child's teeth brushed per day? _____	
Does the child suck his/her thumb, fingers or use a pacifier?	Yes/No
At what age did the child stop bottle feeding or breast feeding? _____	

Parent / Legal Guardian Signature:_____**Date:** _____