PEDIATRIC HEALTH HISTORY FORM

Patient Name:_____ Date of Birth:_____

Today's Date: _____

What is the reason for patient's medical appointment today?: _____

When was patient's last Medical visit? _____ Who is patient's Primary Medical Provider? _____

What is the reason for patient's dental appointment today? _____

When was patient's last Dental visit? _____ Who is patients Primary Dental Provider? _____

ALLERGIES: Please include medications such as Sulfa, Penicillin, Aspirin, Codeine, other drugs/medications, and Latex, Metals, dental materials, or food	**REACTION (hives, rash, etc.)**

MEDICATIONS, VITAMINS, HERBAL SUPPLEMENTS CURRENTLY TAKING:	**DOSE:**	**HOW OFTEN:**

What Pharmacy do you use? _____ Street: _____

City: _____ State: _____

Birth History: **Hospitalizations/Surgeries/Injuries:**

Born at Hospital ___ YES ___NO Other: _____ Mothers age at childbirth: _____	(please select below) Normal vaginal delivery: ____ C- Section: ____ Any complications? Please Explain: _____	**Reason for Hospitalization/Injury/ or type of Surgery:**	**Year:**
Birth Stats: _____lbs. _____oz. _____ inches			

SOCIAL HISTORY

Living Status: ___Alone ___ With Parents ___ With parent/stepparent ___ With one parent_____ ___ Other _____

Does the pediatric patient have any siblings (if so, please provide the number of each)?

___ Only Child ___ Sister(s)

___ Brother(s) ___ Stepsister(s)

___ Stepbrothers(s)

Diet: ___ Bottle ___ Nursing How many times daily does patient eat? ____ How many oz daily____

Does the patient follow a specific diet? _____ (low carb, low fat, gluten free, etc.)

Current grade in school? _____

Caffeine: ___ Never ___ Past ___Current Type: ___ Coffee ___ Tea ___ Soda ___ Energy Drinks ____
How many cups daily? _____

Exercise: ____ None ___ Aerobics ___ Walking ___ Weightlifting ___ Other: _____ _____Days/Weekly

Is patient current on immunizations? YES NO If immunizations were not completed at Eagle View Community Health System, where were they completed? _____
May we obtain these records? (please circle) YES NO

Health History:

Check each item	**Yes**	**No**	**Check each item**	**Yes**	**No**
Alcohol use - Do you have a desire to quit? Yes No			(Hypotension) Low Blood Pressure		
Anemia or other blood disease			Meningitis		
Anorexia			Menstrual difficulties		
Appendicitis, acute or chronic			Mononucleosis		
Arthritis			Nervous or mental disease		
Artificial Heart Valves			Pacemaker		
Asthma			Pneumonia		
Autism			Poliomyelitis		
Back problems			Pregnancies		
Binge eating			Psychiatric Care		
Bleeding Abnormalities			Recreational Drugs:(i.e. Meth, Cocaine, Ecstasy) - Do you have a desire to quit? Yes No		
Bronchitis			Respiratory Disease		
Cancer : Please list Type:			Rheumatic fever		

_____					
Chemotherapy or Radiation Treatments			Hernia		
Cardiovascular disease			Sexually transmitted diseases		
Chickenpox			Shortness of Breath		
Depression/Anxiety			Sinus disease		
Diabetes			Skin disease		
Ear infections, disease, mastoid, etc.			Smoker - Do you have a desire to quit? Yes No		
Emphysema/COPD			Stroke		
Epilepsy or convulsive disorder			Swollen Neck Glands		
Gallbladder disease			Thyroid trouble		
Glaucoma			Tonsillitis		
Hay fever			Tuberculosis		
Headache			Tumor or growth on head or neck		
Hearing Loss			Ulcer, stomach or duodenal		
Hepatitis			Vertigo (dizziness) or fainting spells		
HIV infection			Vomiting or losing weight		
Hypertension (High Blood Pressure)			Whooping cough		
Jaw Pain			Liver disease		
Jaundice			Kidney disease		
Injuries (serious)					

If yes, please explain:

_____

FAMILY HISTORY: Do any of your blood relatives have a history of any of the following? If so, please circle and state family relationship.

	Family Relationship		**Family Relationship**
Cancer: Yes/ No Type_____		Kidney Disease	
Heart Disease		Diabetes	
High Blood Pressure		Nervous or Mental disease	
Liver Disease		Asthma or Hay Fever (allergies)	
Stroke		Convulsions	
Tuberculosis		Stomach Disease	
Lung Disease		Alcohol or Drug Use	

PEDIATRIC DENTAL HISTORY: (Please circle the answer)

Is the patient experiencing pain/discomfort today? YES NO	Do patient's gums bleed when brushing teeth or flossing? YES NO

Has patient ever been diagnosed with any health conditions that require a pre-medication antibiotic before dental treatment? YES NO Please Explain: _____	How many times per day does patient floss? ____ Brush? _____ Type of Bristles: ___Hard __Medium __Soft
Is the patient unhappy with the appearance of his/her teeth? YES NO	Does patient have regular dental check ups? YES NO - Date of Last Exam: _____ - Date of Last XRays: _____
Does patient suffer from pain in mouth, face, neck, throat or jaw (TMJ)? YES NO	Is patient taking fluoride supplements? YES NO
Does the patient have fear which has prevented patient from seeking dental care? YES NO	Does the water patient drinks contain fluoride? YES NO UNKNOWN
Is patient allergic to any metals or dental materials? YES NO	When was the last date of fluoride application? _____
Has the patient ever had any of the following dental treatments? (please circle) Fillings Crowns Braces Implants Root Canal Oral Surgery Bridges Implants	

AGREEMENT & CONSENT

The undersigned may voluntarily seek medical, dental, and/or surgical treatment or diagnosis from the health care and dental providers at EVCHS. I hereby authorize and give consent for dental radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for the diagnosis of the patient's dental needs, as well as laboratory tests, X-rays, EKGs, and other routine medical treatment and diagnostic procedures as may be necessary at any given time. The undersigned consents to and authorizes all treatments, the performance of minor operations and the administration of local anesthetics, and any or all other technical procedures which in the judgement of the health care provider may be considered necessary or advisable for diagnosis and/or treatment. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services rendered. I authorize release of any information to my insurance company related to my medical/dental claims.

My signature as follows verifies that I am the patient or the parent/guardian/legal custodian of the patient as named above.

Signature of Patient or parent/guardian/Legal Custodian: _____

Printed Name of Patient or parent/guardian/Legal Custodian: _____

Relationship to patient: _____ Date: _____