Dr. Egg Pediatric Dentistry

PATIENT NAME: _____ DATE: _____

HEALTH HISTORY

Name of Physician: _____ **Physician Phone #** _____

Please list any medications (name, dose, reason) your child is currently taking:

_____

Please list **ANY allergies** your child has, including medications:

_____

Is your child in good health? ☐ YES ☐ NO If NO, please explain: _____

Date of last physical exam: _____

Is your child up to date on all vaccinations? □ YES □ NO If NO, please explain:_____

****IF YOUR CHILD IS NOT UP TO DATE ON ALL VACCINATIONS, WE WILL NOT BE ABLE TO PROVIDE SERIVCE****

Were there any problems at birth? ☐ YES ☐ NO If YES, please explain: _____

Please check if your child has been treated for any of the following:

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma/Breathing
- ☐ Autism
- ☐ Adverse Drug Reactions
- ☐ Bleeding/Transfusions
- ☐ Cancer/Tumors
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Congenital Birth Defects
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Endocrine/Growth
- ☐ Eyesight
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver/GI Disease
- ☐ Peanut Allergy
- ☐ Personality/Social
- ☐ Physical Delays
- ☐ Recurrent Headaches
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Speech/Hearing
- ☐ Tuberculosis
- ☐ OTHER

Please elaborate on any items checked: _____

_____

_____

Please list any surgeries or hospitalizations:

_____

_____

Do you consider your child to be: □ Advanced in the learning process □ Processing Normally □ Slow in the learning process

Parent/Guardian Signature:_____ Date:_____