Martha E. Rich, DMD, PC
Child Health History

Please complete the following confidential information:

Today's Date _____ Date of Birth _____

Name _____ Please circle one: Male Female

Family History--Does your child/child's relative have a history of any of the following:
(Please indicate **C** for child's condition and **F** for family history)

Asthma	_____	Diabetes	_____	ADD / ADHA	_____
Cancer	_____	Rheumatic Fever	_____	Hemophilia	_____
Heart Murmur	_____	Hepatitis A	_____	Congenital Heart Disease	_____
HIV/AIDS	_____	Hepatitis B	_____	Cardiovascular Disease	_____
Tuberculosis	_____	Hepatitis C	_____	Convulsions/Epilepsy	_____

Any conditions/symptoms not listed here _____
_____

Please list any medications, drugs, vitamins, herbs, or other supplements your child is taking:
_____

Does your child have any allergies (environmental, medications, anesthetic, food, etc.)?
_____

How often does your child brush? _____ Do you help?_____
How often does your child floss? _____ Do you help?_____
Is your water fluoridated?_____ Does your child take fluoride supplements? _____
Has your child had his/her tonsils removed? _____If so, when? _____
While asleep, does your child breathe through his/her mouth? _____nose? _____
Was your child born prematurely? Yes ◯ No ◯
Does your child get ear infections? Yes ◯ No ◯
Does your child get throat infections? Yes ◯ No ◯
Does your child get headaches? Yes ◯ No ◯
If so, how often? _____
Does your child experience clicking or popping of the jaw joint? Yes ◯ No ◯

How many times a day does your child eat something with sugar or high fructose corn syrup?

Weekdays _____ Weekends _____

Does your child do any of the following:

Suck thumb or fingers	_____	Chew pencils	_____	Snore	_____
Suck/bite lips	_____	Grind teeth	_____		
Bite/chew nails	_____	Clench jaw	_____		

How many times a week does your child eat the following:

Fruit bars	_____	Fruit roll-ups	_____	Dried fruit	_____
Granola bars	_____	Energy bars	_____	Candy/gum	_____

How many times a week does your child drink the following:

Soda	_____	Juice	_____	Soy milk	_____
Energy drinks	_____	Sports drinks	_____	Bottled tea	_____
Vitamin water	_____	Hot chocolate or Chocolate milk			_____

How much plain water does your child drink per day? _____

Does your child snore at night?	Yes ◯	No ◯
Does your child thrash at night?	Yes ◯	No ◯
Does your child sleepwalk?	Yes ◯	No ◯
Does your child grind their teeth?	Yes ◯	No ◯
If yes, when?	Daytime ◯	Nighttime ◯

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental staff of any changes in my child's medical status. I authorize the release of dental records to other providers treating my child should it become necessary.

Signature _____ Print Name _____

Relationship to Child _____