HEALTH HISTORY UPDATE

Patient's name: _____Date of Birth: _____

1. Is your child currently taking any medications? ▫ No ▫ Yes,
   What? _____
2. Is your child allergic to any medications? ▫ No ▫ Yes,
   What? _____
3. Has your child been in the hospital since the last visit? ▫ No ▫ Yes,
   What? _____
4. Any surgeries or medical treatment being contemplated? ▫ No ▫ Yes,
   What? _____
5. Is your child taking or using any fluoride (other than toothpaste)? ▫ No ▫ Yes,
   What? _____
6. Does your child:
   a. Suck thumb/finger? ▫ No ▫ Yes, What?
      _____
   b. Grind teeth? ▫ No ▫ Yes, What?
      _____
7. Any recent dental problems? ▫ No ▫ Yes, What?
   _____

Signature_____ Relationship: _____
Date: _____