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?

Parent/Responsible Party Name____

Signature: _____________________________________Relationship: ____________________

Date: ____________________

PLEASE FILL OUT THIS SIDE ONLY
&
GIVE THIS FORM TO THE DENTAL ASSISTANT