MATT W. ANDERSON, DDS, PC
HEALTH HISTORY FORM

Patient's Name:_____ DOB:_____
Preferred Name:_____ Birth Sex: M F Current Gender Identity:_____

Family Address: _____City:_____ State:_____ Zip:_____

Parent/Guardian's Name: _____ Relation to PT:_____DOB:_____
Phone:_____ Email:_____
Parent/Guardian's Name: _____ Relation to PT:_____DOB:_____
Phone:_____ Email:_____

Who would like to receive reminder/scheduling calls:_____
Who is financially responsible for the account:_____
Name of Insurance Holder:_____ Relation to PT:_____DOB:_____

Physician Name/Phone:_____
Is your child being followed by a physician at this time? Reason_____
_____
Is your child taking any medications? If yes, list name, dose, frequency_____
_____
Has your child ever been hospitalized, had surgery or a significant injury or been treated in the ER? If yes, please list_____
Was your child born prematurely? Yes No
If yes, were they on a respirator/how long were they in the NICU? _____
Has your child ever had a reaction to an anesthetic? Describe _____
Has your child ever had a reaction or allergy to an antibiotic, sedative or other medication? List
_____
Is your child up to date on immunizations against childhood disease? Yes No
Has the child had any history of or conditions related to any of the following: (circle any that apply)

Allergies:_____	Yes	No	Hearing Impaired	Yes	No
(Seasonal/Latex/Medication)			Heart	Yes	No
Anemia	Yes	No	Hepatitis	Yes	No
Arthritis	Yes	No	Herpes	Yes	No
Autism	Yes	No	HIV/AIDS/STD	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No
Bleeding disorders	Yes	No	Liver Disease	Yes	No
Bladder Issues	Yes	No	Measles	Yes	No
Bones/Joints	Yes	No	Mononucleosis	Yes	No
Cancer	Yes	No	Mumps	Yes	No
Cerebral Palsy	Yes	No	Pregnancy (teens)	Yes	No
Chicken Pox	Yes	No	Seizures	Yes	No
Chronic Sinusitis	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Sickle Cell Anemia	Yes	No
Developmental Disability	Yes	No	Thyroid Disease	Yes	No
Ear Aches/Ear Tubes	Yes	No	Alcohol/Tobacco/Drug Use	Yes	No
Epilepsy	Yes	No	Tuberculosis	Yes	No
Fainting	Yes	No	Other:_____		
Growth Problems	Yes	No			

What is your primary concern about your child's oral health?_____
_____

How would you describe:

Your child's heath?	Excellent	Good	Fair	Poor
Your oral health?	Excellent	Good	Fair	Poor
The oral health of your other children?	Excellent	Good	Fair	Poor

Is there a family history of cavities? Yes No If yes, circle all that apply: Mother Father Siblings

Does your child have a history of any of the following?

Inherited dental characteristics	Yes	No	Injury to tooth, mouth or jaw	Yes	No
Mouth sores or fever blister	Yes	No	Clinching/grinding of teeth	Yes	No
Bad breath	Yes	No	Jaw joint problems (popping, etc)	Yes	No
Bleeding Gums	Yes	No	Excessive gagging	Yes	No
Toothache	Yes	No	Sucking habit after one year of age?	Yes	No

How often does your child brush their teeth? _____ times per _____

Does someone help your child brush their teeth? Yes No

What type of toothbrush/toothpaste does your child use? _____

Please circle all sources of fluoride your child receives:
Drinking water Toothpaste Over the counter rinse Prescription gel/rinse Fluoride in dental/medical office

Does your child regularly eat 3 meals each day? Yes No
Is your child on a special or restrictive diet? Yes No If yes, please describe_____

How frequently does your child have the following?

Snacks between meals	Rarely	1-2xs per day	3 or more per day
Candy or other sweets	Rarely	1-2xs per day	3 or more per day
Chewing Gum	Rarely	1-2xs per day	3 or more per day
Soft Drinks, juice, etc?	Rarely	1-2xs per day	3 or more per day

Has your child been examined by another dentist? Yes No
If yes, date of last visit: _____ Reason for Visit: _____
Were x-rays take? Yes No
Has your child ever had orthodontic treatment? If yes, where?_____
Has your child ever had a difficult dental treatment? If yes, describe: _____

Is there anything else we should know about your child? If yes, please describe Yes No
_____
_____
_____

How did you hear about Dentistry for Children?_____

Parent/Guardian's Signature:_____ Date:_____