Children's Dental Center of SE Iowa
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New Patient Health History Form

1. Is your child in good health? .... YES NO
2. Has there been any change in your child's health within the past year? .... YES NO
3. Date of last physical exam ____________
4. Is your child now under medical care? .... YES NO
   If so, for what? ____________
5. Has your child ever had a serious illness or operation? .... YES NO
   If so, explain ____________
6. Does your child have or has he/she ever had any of the following diseases?
   a. Rheumatic fever or rheumatic heart disease .... YES NO
   b. Congenital heart disease .... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .... YES NO
   d. Allergy .... YES NO
   e. Asthma or hay fever .... YES NO
   f. Hives or a skin rash .... YES NO
   g. Fainting spells or seizures .... YES NO
   h. Hepatitis, jaundice, or liver disease .... YES NO
   i. Diabetes .... YES NO
   j. Inflammatory rheumatism (painful, swollen joints) .... YES NO
   k. Arthritis .... YES NO
   l. Stomach ulcers .... YES NO
   m. Kidney trouble .... YES NO
   n. Tuberculosis .... YES NO
   o. Persistent cough or cough up blood .... YES NO
   p. Venereal disease .... YES NO
   q. Epilepsy .... YES NO
   r. Cerebral palsy .... YES NO
   s. Mental retardation .... YES NO
   t. Hearing disability .... YES NO
   u. Other disease .... YES NO
      If so, explain ____________
   v. Other developmental disability .... YES NO
      If so, explain ____________
7. Does your child have to urinate (pass water) more than 6 times a day? .... YES NO
8. Is your child thirsty much of the time? .... YES NO
9. Has your child had abnormal bleeding associated with previous surgery, extractions, or accidents? .... YES NO
10. Does he/she bruise easily? .... YES NO
11. Has he/she ever required a blood transfusion? .... YES NO
12. Does she/he have any blood disorders such as anemia, and so forth? .... YES NO
13. Has he/she ever had surgery or x-ray treatment for a tumor, growth, or other condition? .... YES NO
14. Does your child have a disability that prevents treatment in a dental office? .... YES NO
15. Is he/she taking any of the following?
    a. Antibiotics or sulfa drugs .... YES NO
    b. Anticoagulants (blood thinners) .... YES NO
    c. Medicine for high blood pressure .... YES NO
    d. Cortisone or steroids .... YES NO
    e. Tranquilizers .... YES NO
    f. Aspirin .... YES NO
    g. Dilantin or other anticonvulsant .... YES NO
    h. Insulin, Tolbutamide, Orinase, or similar drug .... YES NO
    i. Any other? ____________
16. Is he/she allergic to or has he/she ever reacted adversely to any of the following?
    a. Local anesthetics .... YES NO
    b. Penicillin or other antibiotics .... YES NO
    c. Sulfa drugs .... YES NO
    d. Barbiturates, sedatives, or sleeping pills .... YES NO
    e. Aspirin .... YES NO
    f. Any other? ____________
17. Has he/she had any serious trouble associated with any previous dental treatment? .... YES NO
    If so, please explain ____________
18. Has he/she had any disease, condition, or problem not listed above? .... YES NO
    If so, please explain ____________
19. Has your child been in any situation which could expose him/her to x-rays or other ionizing radiations? .... YES NO
20. Last date of dental exam ____________
21. Has he/she ever had orthodontic treatment (worn braces?) .... YES NO
22. Has he/she ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)? .... YES NO
23. Do his/her gums bleed when brushing teeth? .... YES NO
24. Does he/she grind or clench teeth? .... YES NO
25. Has he/she often had toothaches? .... YES NO
26. Has he/she had frequent sores in mouth? .... YES NO
27. Has he/she had any injuries to mouth or jaw? .... YES NO
    If so, explain ____________
28. Has he/she have any sores or swellings of the mouth or jaw? .... YES NO
29. Have you been satisfied with your child's previous dental care? .... YES NO

ADOLESCENT WOMEN

30. Are you pregnant? .... YES NO
31. Do you have any problems associated with your menstrual period? .... YES NO
32. Are you taking birth control pills? .... YES NO

The undersigned agrees that the information above is accurate.

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Parent/Guardian Signature

Children's Dental Center of SE IA requests this information for the purpose of providing a complete and comprehensive evaluation of your child's dental needs. No persons outside the office will be provided with this information unless properly

authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your child's needs and may result in Children's Dental Center of SE IA being unable to accept your child for treatment.