CHILDREN'S DENTISTRY OF COFFEE CREEK - DON CHEATHAM, DDS

HEALTH HISTORY UPDATE

Today's date: ________________ Patient's Name: _______________________Date of Birth_____________

Change of Address: ____
Change of Phone Number: ___________________________ Cell phone(s)________________,______________
Current email address: ____
Change in Insurance Coverage: ____

Name of child's physician: ____
Physician's Phone Number: ______________ Date of Last Visit to the Doctor:_______________________

Is your child in good health? YES _____ NO _____
Is your child currently under a doctor's care? YES ____ NO ____
If yes, please explain ____

Has your child be hospitalized in the past year? ____
Is your child currently taking any of the following? If yes, please name.

Prescription medications: ____
Natural remedies: ____
Over the counter medications: ____
Vitamins: ____
Dieting Aids: ____

Has your child had an allergic reaction or sensitivity to any medications? YES_____ NO ______
If yes, please explain: ____
Has your child ever had a negative reaction to local anesthetic? YES ____ NO ____
Has your child ever had a negative reaction to general anesthetic? YES ____ NO ___
If yes to either of the above, please explain: ____
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Does your child have any history of the following? Please check if applicable:

- ☐ ADD/ADHD
- ☐ Alcohol Use
- ☐ Anemia
- ☐ Anorexia Nervosa
- ☐ Antibiotic Prophylaxis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding (prolonged)
- ☐ Blood transfusion
- ☐ Bronchitis/Pneumonia
- ☐ Bulimia
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cleft lip/palate
- ☐ Cocaine Use
- ☐ Diabetes
- ☐ Dye (ex: Red Dye # 40)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis (A, B, or C)
- ☐ Kidney Disorder
- ☐ Latex Allergy
- ☐ Leukemia
- ☐ Liver Disorder
- ☐ Malignant hyperthermia
- ☐ Methamphetamine Use
- ☐ Nickel Allergy
- ☐ Oral Contraceptives
- ☐ Pregnant (currently)
- ☐ Prosthesis
- ☐ Psychiatric Counseling
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Speech/Hearing
- ☐ Stomach Disorder
- ☐ Tobacco Products
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other

☐ No Existing Medical Conditions

Please elaborate if any of the above is checked: ____
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Name and number of closest relative: __________________________ # _______________ relationship: _________

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Signature of Parent or Legal Guardian Date