THE BEACH HOUSE
PEDIATRIC
DENTISTRY & ORTHODONTICS

Health Questionnaire

Patient Name: _____ Age:_____Sex:_____ Date of Birth: _____

Date of last physical exam:_____ Physician's Name:_____

Is your child being treated by a physician?
Yes No
Reason: _____
Is your child taking any medication?
Yes No
If so, list name, dose and reason: _____
Has your child been hospitalized, had surgery or significant injury or illness?
Yes No
Describe: _____
Has your child ever had a reaction to or problem with anesthesia?
Yes No
Describe: _____
Has your child every had a reaction or allergy to a medication?
Yes No
Describe: _____
Is your child allergic to latex or any other material such as dye or metal?
Yes No
Describe: _____
Is your child up to date on immunizations?
Yes No
Is your child immunized against human papilloma virus (HPV)?
Yes No

Has your child ever had a history of the following: If "YES" please check and provide details below.
_____Complications before or during birth, prematurity, birth defects, syndromes or inherited conditions.
_____Problems with physical growth or development.
_____Sinusitis, chronic adenoid/ tonsil infections.
_____Sleep apnea/ snoring, mouth breathing or excessive gagging.
_____Congenital heart defect/ disease, heart murmur, rheumatic fever, rheumatic heart disease.
_____Irregular heart beat or high blood pressure.
_____Asthma, reactive airway disease, wheezing, or breathing problems.
_____Cystic fibrosis.
_____Frequent cold or coughs, pneumonia.
_____Frequent exposure to tobacco smoke.
_____Jaundice, hepatitis or liver problems.

THE BEACH HOUSE
PEDIATRIC
DENTISTRY & ORTHODONTICS

_____Gastroesophageal reflux disease (GERD), stomach ulcer or intestinal problems.
_____Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions.
_____Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder.
_____Bladder or kidney problems.
_____Fine/ gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems.
_____Rash/ hives, eczema, or skin problems.
_____Impaired vision, visual processing, hearing or speech.
_____Developmental disorders, learning problems/ delays, or intellectual disability.
_____Cerebral palsy, brain injury, epilepsy, or seizures/ convulsions.
_____Autism/ Autism spectrum disorder.
_____Recurrent or frequent headaches, migraines, fainting or dizziness.
_____Hydrocephaly or placement of shunt.
_____Attention deficit/ hyperactivity disorder (ADD/ADHD).
_____Behavioral, emotional, communication or psychiatric problems.
_____Abuse (physical, psychological, emotional or sexual) or neglect.
_____Diabetes, hyperglycemia, hypoglycemia.
_____Precocious puberty or hormonal imbalances.
_____Thyroid or pituitary problems.
_____Anemia, sickle cell disease/ trait, or blood disorder.
_____Hemophilia, bruising easily, or excessive bleeding.
_____Transfusions or receiving blood products.
_____Cancer, tumor or other malignancy. Chemotherapy, radiation therapy, bone marrow or organ transplant.
_____Mononucleosis, scarlet fever, TB, CMV, MRSA, STD, HIV, AIDS.

Provide details here:
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

_____ _____
Signature (Patient, Parent or Guardian) Date