WHF
WISCONSIN HEALTH FUND

Child Health/Dental History Form

Patient's Name LAST FIRST INITIAL	Nickname	DOB
Parent's/Guardian's	Relationship to Patient	
Address CITY STATE ZIPCODE		
Home Phone: Work:	Patient's sex ☐ Female ☐ Male	

Has the child had any history of, difficulty with, or diagnosis of any of the following:

❑ Anemia	❑ Cancer	❑ Fainting	❑ Immunizations	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Growth Problems	❑ Kidney	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Hearing	❑ Latex Allergy	❑ Pregnancy	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Heart	❑ Liver	❑ Rheumatic Fever	❑ Venereal Disease
❑ Bleeding Disorders	❑ Diabetes	❑ Hepatitis	❑ Measles	❑ Seizures	❑ Other__________
❑ Bones/Joints	❑ Epilepsy	❑ HIV+/AIDS	❑ Cold Sores	❑ Sickle Cell	

Please list the name and phone number of the child's physician:

Name of Physician ____ Phone ____

CHILD'S MEDICAL HISTORY

	Yes	No
1. Is the child taking any medications at this time? If yes, please list: ____	❑	❑
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ____________________	❑	❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: ______________________________________	❑	❑
4. How would you describe the child's eating habits? ____	❑	❑
5. Has the child ever had a serious illness? If yes, when: _______________ Please describe: _______________________________	❑	❑
6. Has the child ever been hospitalized? If yes, when: _________________ Please describe: _______________________________	❑	❑
7. Does the child have a history of any other illnesses?	❑	❑
8. Has the child ever received a general anesthetic?	❑	❑
9. Does the child have any speech difficulties?	❑	❑
10. Has the child ever had a blood transfusion?	❑	❑
11. Is the child physically, mentally or emotionally impaired?	❑	❑
12. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? ___________________	❑	❑
13. Has the child had any problem with dental treatment in the past?	❑	❑
14. Has the child ever suffered any problems with the eruption or shedding teeth?	❑	❑
15. Has the child had any orthodontic treatment?	❑	❑
16. What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water		
17. Does the child take fluoride supplements?	❑	❑
18. Is fluoride toothpaste used?	❑	❑
19. How many times are the child's teeth brushed per day? _______ When are the teeth brushed? _______________________		
20. Does the child suck his/her thumb, fingers or pacifier?	❑	❑
21. At what age did the child stop bottle feeding? Age _______ Breast feeding? Age ________		

NOTE: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's Guardian's Signature ____ Date ______________________________

For completion by dentist

Comments from patient interview concerning health history ____
____

Significant findings from questionnaire or oral interview ____
____

Dental management considerations ____
____

Signature of Dentist ____