



# CHILD'S HISTORY

THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD.

Child's full name \_\_\_\_\_

Nickname \_\_\_\_\_

Age \_\_\_\_\_ Birthday \_\_\_\_\_ Birthplace \_\_\_\_\_

Is your child in good health? .....	<b>Yes No</b>	Was your child a full term baby or premature?	
Does your child have regular medical examinations?	<b>Yes No</b>	Was your child breastfed _____ mos. Bottle fed _____ mos.?	
Has your child ever had any of the following medical problems?		Any Brothers _____ or Sisters _____	
Heart Murmur	<b>Yes No</b>	Congenital Heart Defect	<b>Yes No</b>
Cancer	<b>Yes No</b>	Convulsions / Epilepsy	<b>Yes No</b>
Diabetes	<b>Yes No</b>	Abnormal Bleeding	<b>Yes No</b>
Rheumatic Fever	<b>Yes No</b>	Hearing Impaired	<b>Yes No</b>
HIV+ / AIDS	<b>Yes No</b>	Any Operations	<b>Yes No</b>
Hemophilia	<b>Yes No</b>	Any stays in a hospital	<b>Yes No</b>
Asthma	<b>Yes No</b>	Kidney / Liver Problems	<b>Yes No</b>
Hepatitis	<b>Yes No</b>	Handicaps / Disabilities	<b>Yes No</b>
Tuberculosis (TB)	<b>Yes No</b>	Allergies to drugs	<b>Yes No</b>
Cerebral Palsy	<b>Yes No</b>	Autism	<b>Yes No</b>
Latex Allergy	<b>Yes No</b>		
<b>PURPOSE OF CALL</b>		<input type="checkbox"/> Examination	<input type="checkbox"/> Emergency
		Any family history of malignant hyperthermia?	<b>Yes No</b>

**The Parent or Guardian who accompanies the child is responsible for payment at time of service.**

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. **I also authorize Dr. Savide and his staff to perform the necessary dental services my child may need.**

Signature of Parent of Guardian \_\_\_\_\_

Date \_\_\_\_\_

### OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_