LITTLE CHOMPERS
PEDIATRIC DENTISTRY

Health History Update

First Name:	Last Name:	Birthdate:
Address:	Phone:	
Pediatrician		

Does your child require premedication for dental treatment (prosthetic heart valve or similar)? ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list all medications your child is currently taking in the highlighted fields and check the box next to them.

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☐ ☐ ☐ ☐

Check any allergies your child has to any of the following. Add any not listed under OTHER and check the box next to them.

☐ Anesthetic	☐ Ibuprofen (Motrin)	☐ Lactose	☐ Gluten/Wheat	☐ Latex
☐ Aspirin	☐ Iodine	☐ Casein	☐ Shellfish	☐ Pet fur/dander
☐ Cephalosporins	☐ Penicillin/Amoxicillin	☐ Soy	☐ Eggs	Other
☐ Codeine	☐ Sulfa/Sulfonamides	☐ Peanuts	☐ Strawberries	☐
☐ Erythromycin	☐ Tetacycline	☐ Tree Nuts	☐ Bananas	☐

Has your child had any of the following conditions or treatments within the last 2 weeks?

☐ Acid Reflux (GERD)	☐ Bladder Infection	☐ Emotional disturbance	☐ Pneumonia
☐ Adenoiditis	☐ Bleeding disorder	☐ Epilepsy	☐ Pregnancy
☐ ADHD	☐ Celiac Disease	☐ Fifth Disease	☐ Respiratory Problem
☐ Allergies/Hay Fever	☐ Cerebral Palsy	☐ Hand, Foot & Mouth	☐ Sensory Issues
☐ Anemia	☐ Cold	☐ Hearting/Speech problem	☐ Sinus Problem
☐ Anxiety disorder	☐ Concussion	☐ Heart Murmur	☐ Strep Throat
☐ Asperger's Syndrome	☐ Diabetes	☐ Influenza (Flu)	☐ Tonsillitis
☐ Asthma	☐ Ear Infection	☐ Kawasaki Disease	☐ Urinary Tract infection
☐ Autism	☐ Eczema	☐ Mouth Ulcers	☐ Whooping Cough

Please elaborate as necessary for any checked conditions:

Are there any other conditions or treatments not listed above? ☐ Y Please describe:

Has your child had his/her tonsils removed? Yes/No

Has your child had his/her adenoids removed? Yes/No

Are there any other recent and/or pending surgeries? Yes/No

Please list:

Please list any of your child's recent positive or negative medical/dental experiences that you feel are relevant:

Dental History Update

Has your child had any injuries to his/her head, face, mouth or teeth?

☐ Yes ☐ No Dates and specifics:

Are there any particular concerns with your child's teeth or with his/her dental and oral health?

☐ Yes ☐ No Please explain:

Parent/Guardian signature: _____ Date: _____