Susan K. Blair, D.D.S.
Wanda Nguyen, D.M.D.
Anupama Krishnamurthy, D.D.S.

CONFIDENTIAL HEALTH HISTORY FORM

Please fill out all applicable information completely.

Patient's Name: _____ Nickname: _____ Birthdate: _____

Residence/Street: _____ Home Phone: _____ Sex: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Parent/Guardian Name: _____ Employer: _____ SS#: _____

Cell Phone: _____ Work Phone: _____ Birthdate: _____ Marital Status: S / M / D / W

Parent/Guardian Name: _____ Employer: _____ SS#: _____

Cell Phone: _____ Work Phone: _____ Birthdate: _____ Marital Status: S / M / D / W

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Address: _____ Date of Last Medical Exam: _____

Are your child's immunizations up to date? □ Yes □ No Is your child currently taking any medications? □ Yes □ No

Medications: (Please include dose & frequency) _____

Significant injuries (such as head or teeth, broken bone, car accidents)? Please describe: _____

_____Height: _____ Weight: _____

DOES THE PATIENT HAVE OR HAD ANY OF THE FOLLOWING?
Please indicate with an (X)

- □ Allergies (skin rashes, medication, food, dust, other _____)
- □ Anemia or blood problems (Sickle Cell)
- □ Arthritis/Joint pain
- □ Asthma/Breathing problems
- □ Bleeding problems
- □ Bone or Muscular problems
- □ Bronchitis
- □ Cancer/other tumors
- □ Cerebral Palsy
- □ Chicken Pox
- □ Diabetes
- □ Ear/Hearing
- □ Endocrine/Glandular problems
- □ Eye/Vision problems
- □ Handicaps (mental, physical, emotional)
- □ Heart defects
- □ Hepatitis/Jaundice
- □ Immuno Suppressive (A.I.D.S.) Disease
- □ ***Hospitalizations***:_____
- □ Venereal Disease
- □ Kidney/Urinary Tract problems
- □ Learning Disorders_____
- □ Measles
- □ Mumps
- □ Nervous/Seizure problems
- □ Pregnancy
- □ Rheumatic Fever
- □ Radiation Treatments
- □ Scarlet Fever
- □ Stomach/Digestive problems
- □ **None**

DENTAL HISTORY

Current Dentist's Name: _____Phone: _____

Address: _____Date of Last Dental Exam: _____

Has the patient had any unfavorable dental experiences? **YES NO** If yes, please explain: _____

Chief Oral Complaint: _____

DOES THE PATIENT HAVE OR USE ANY OF THE FOLLOWING?
Please indicate with an (X)

- □ Traumatic injury to mouth or teeth
- □ Sensitivity to cold/hot/sweet/pressure
- □ Bleeding gums? How long_____
- □ Food impaction
- □ Clenching or grinding of teeth
- □ Swelling or lumps in mouth
- □ Frequent blisters on lips or mouth
- □ Pain around the ears
- □ Bad Breath
- □ Complications from extractions
- □ Topical Fluoride Treatment
- □ Orthodontic Treatment or Supplements
- □ Mouth breathing
- □ Bedtime nursing bottle
- □ Toothbrush texture_____
- □ Brushing frequency _____
- □ Dental Floss frequency _____
- □ Disclosing tablets/solutions
- □ Between meal snacks
- □ Well-balanced diet
- □ Oral habits: thumb sucking, nail biting, pacifier, cheek biting, tongue thrusting

Describe any current medical treatment including drugs taken, even though not listed above:

_____

Is there anything that you feel Children's Dentistry Group should know about the patient?

_____

I certify that I have read and understand the above question. I will not hold Children's Dentistry Group, LLC responsible for any errors or omissions I may have made in completion of this form.

Signature of Person Completing Form: _____

Relationship to Patient: _____ Date: _____