wesley Health Centers JWCH INSTITUTE

Pediatric Health History Questionnaire

Patient Name_____Date of Birth_____/_____/_____Chart#_____

Please Circle the appropriate answer

1. Does your child have any health problems? YES NO
2. Was your child a patient in a Hospital? YES NO
If yes Explain_____
3. Is your child under any medical care? YES NO
If yes for what? _____ YES NO
4. Is your child taking any medication now?
If so what? _____
5. Has your child ever had a serious illness or operation? YES NO
If ye, Explain_____

Does your child have (Or have ever had any of the following diseases) ?

a. Rheumatic fever or Rheumatic heart disease? YES NO
b. Congenital heart disease? YES NO
c. Cardio vascular disease? (High blood pressure) YES NO
d. Allergies to food or medicine? YES NO
If so what are they_____
e. Hives or skin rash? YES NO
f. Fainting or seizures? YES NO
g. Diabetes? YES NO
h. Arthritis? YES NO
i. Stomach ulcers? YES NO
j. Tuberculosis (TB)? YES NO
k. Veneral Disease? YES NO
l. Epilepsy? YES NO
m. Sickle cell disease? YES NO
n. AIDS? YES NO
o. Psychiatric treatment? YES NO
P. Cerebral palsy? YES NO
q. Mental retardation? YES NO
r. Hearing disability? YES NO
s. Autism or ADHD? YES NO
6. Is your child thirsty much of the time? YES NO
7. Does your child bruise easily? YES NO
8. Does your child have any blood disorders? YES NO
9. Does your child have a disability that can prevent any Dental Treatment?
10. Has your child had any serious trouble with any pervious dental visit?
If so please explain_____
11. Last day of Dental Examination_____
12.Has your child ever had Orthodontic treatment (Braces)? YES NO
13. Has your child ever been treated for Gum Disease? YES NO
14. Do your child's teeth bleed when brushing teeth? YES NO
15. Does your child grind their teeth? YES NO
16. Does your child complain about tooth pain? YES NO
17. Has your child had any sores or swellings in mouth? YES NO

Adolescent Woman

18. Are you pregnant now, or think you may be? YES NO
19. Do you anticipate becoming pregnant? YES NO

Dental History

1.Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date:_____ YES NO
2.Has the child had any problem with dental treatment in the past YES NO
3.Has child ever had dental radiographs (X-rays) exposed? YES NO
4.Has the child ever suffered any injuries to the mouth, head or teeth? YES NO
5.Has the child had any problems with the eruption or shedding of teeth? YES NO
6.Has the child had any orthodontic treatment? YES NO
7.What type of water does your child drink?___City water____Bottle water ___Filtered water___Well water
8.Does your child take fluoride supplements? YES NO
9.Is fluoride toothpaste used? YES NO
10.How many times are the child's teeth brushed per day?_____When are the teeth brushed?_____
11.Does the child suck his/her thumb, fingers or pacifier? YES NO
12.At what age did the child stop bottle feeding? Age_____Breast feeding? Age_____
13.Does child participate in active recreational activities? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If ,my child has a change in his/her health or/ her medications change, I will inform JWCH dentist/ staff at the next appointment without fail. I certify that I am the legal guardian of the child named above and below.

Parent's Signature		**Parent's Name (Print)**	
Date Signed		**Parent's Phone**	
Date Signed		**Dentist's Signature**	
Health History Updated			
Date:	**Changes to Health History**	**Parent Signature**	**Providers Signature**