Community Health Center of Snohomish County

Patient ID Label

Health History – Child

Information is for our records only and will be kept confidential

CHILD'S NAME _____/_____/_____ TODAY'S DATE _____
Last First Middle

DATE OF BIRTH: _____ GENDER: ☐ Male ☐ Female

PARENT NAME _____ PHONE _____

IF PERSON COMPLETING THIS FORM IS NOT PARENT, WHAT IS YOUR RELATIONSHIP TO THE PATIENT? _____

NAME OF PHYSICIAN _____ DATE OF LAST PHYSICAL EXAM _____

PHYSICIAN'S ADDRESS: _____

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:_____

IS YOUR CHILD IN GOOD HEALTH? ☐ Yes ☐ No

HAS YOUR CHILD HAD ANY SERIOUS ILLNESS OR OPERATION? ☐ YES ☐ NO

IF "YES" WHAT WAS THE ILLNESS OR OPERATION?_____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES OR PROBLEMS? (Check box for Yes)

- ❑ Damaged heart valves or artificial heart valves
- ❑ Heart murmur
- ❑ Congenital heart lesion
- ❑ Allergy to _____
- ❑ Sinus problems
- ❑ Asthma
- ❑ Hay fever
- ❑ Hives or skin rash
- ❑ Diabetes
- ❑ Hepatitis, jaundice
- ❑ Tuberculosis
- ❑ Persistent cough
- ❑ Epilepsy
- ❑ Fainting or seizures
- ❑ Psychiatric problems
- ❑ Cancer
- ❑ ADHD
- ❑ Blood transfusion
- ❑ Blood disorders
- ❑ HIV/AIDS
- ❑ Other immunosuppressive disorder
- ❑ Bruises easily
- ❑ Irregular menstrual cycle
- ❑ Pregnancy
- ❑ Abnormal bleeding

DOES YOUR CHILD HAVE A HISTORY OF ALLERGIES OR ADVERSE REACTION TO MEDICATIONS? (Check box for Yes)

- ❑ Local anesthetics
- ❑ Iodine
- ❑ Sulfa Drugs
- ❑ Penicillin
- ❑ Other Antibiotics
- ❑ Codeine or any other narcotic
- ❑ Children's Pain Medicine
- ❑ Other Medications

Has your child had any trouble with previous dental treatment? ☐ YES ☐ NO
(If "Yes", please explain)

Does your child have any other disease, condition, or illness you feel we should know about? (If "Yes", please explain)

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

Parent /Guardian Signature	Printed Name of Interpreter	Interpreter Signature
Dentist Signature/ Date		