

HEALTH HISTORY

| DOB:

Summary

Medical Conditions	none listed
Allergies	none listed
Medications	none listed

Healthcare Provider

Child's Physician/Pediatrician	
Physician/Pediatrician phone number	
Pediatrician's Address	
Preferred Pharmacy	
Date of last physical exam	

General Health Information

Does your child have any allergies?	
Is your child currently taking any medications?	
Has your child ever been hospitalized, had general anesthesia, or emergency room visits?	

Medical Conditions

Has your child received any vaccinations?	
Has your child received a shot(s) for the prevention of COVID19?	
Have you ever been told that your child needs to take antibiotics before dental treatment?	
Were there any difficulties at birth?	
Is your child currently being treated for, or has a history of any medical conditions?	

Patient's signature:

Date:

Doctor's signature:

Date: