PEDIATRIC DENTAL CARE CENTER

316 MARTIN LUTHER KING
TACOMA WA 98467 **(253) 627-6023**

HEALTH QUESTIONARE

PLEASE COMPLETE THE FOLLOWING QUESTIONS. THIS INFORMATION WILL HELP US IN PERFORMING OPTIMUM DENTAL TREATMENT FOR YOUR CHILD. YOUR ANSWERS WILL BE CONSIDERED CONFIDENTIAL AND WILL BECOME A PART OF YOUR CHILD'S PERMANENT DENTAL RECORD.

CHILD'S NAME_____BIRTHDATE_____

PLEASE ANSWER ALL QUESTIONS AND THEN EXPLAIN ALL "YES" ANSWERS UNDER COMMENTS AT BOTTOM OF PAGE.

1. DOES THIS CHILD HAVE A CURRENT MEDICAL PROBLEM? YES NO
2. IS THIS CHILD TAKING ANY MEDICATION NOW? YES NO
3. HAS THIS CHILD EVER BEEN SERIOUSLY ILL OR HOSPITALIZED? YES NO
4. HAVE YOU EVER BEEN TOLD BY A PHYSICIAN THAT THIS CHILD HAS A HEART MURMUR? YES NO
5. HAVE YOU EVER BEEN TOLD BY A PHYSICIAN THAT THIS CHILD HAS HEPATITIS? YES NO
6. DOES THIS CHILD HAVE ASTHMA OR HAY FEVER? (CIRCLE ONE)
7. DOES THIS CHILD HAVE HIVES OR SKIN RASH? (CIRCLE ONE)
8. IS THIS CHILD PHYSICALLY OR MENTALLY CHALLENGED? YES NO

9. HAS THIS CHILD EVER HAD ANY HISTORY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY?

RHEUMATIC FEVER	HEART TROUBLE
ARTHRITIS (JOINT PAIN OR SWELLING)	JAUNDICE (YELLOW SKIN & EYES)
CONVULSIONS (SEIZURES) , EPILEPSY	BLEEDING DISORDERS
DIABETES	H.I.V.
TUBERCULOSIS	KIDNEY OR LIVER INVOLVEMENT
SCARLET FEVER	BLISTERS OR COLD SORES
HEPATITIS	OTHER_____
ATTENTION DEFICIT(ADHD)	

10. HAS THIS CHILD EVER EXPERIENCED AN UNUSUAL REACTION (ALLERGY OR SENSITIZATION) TO ANY OF THE FOLLOWING MEDICINES?
YES_____NO_____IF YES, PLEASE CIRCLE THE ONE BELOW:

ASPRIN	DENTAL, LOCAL ANESTHETICS (USED TO PUT TEETH TO SLEEP)
PENICILLIN	
SULFONAMIDES (SULFA)	OTHER_____
ATARAXICS (TRANQUILIZERS)	_____

11. DOES THIS CHILD HAVE PROBLEMS WITH EXTENSIVE BLEEDING WHEN HE SCRATCHES OR CUTS HIMSELF? YES_____NO_____
12. WHEN DID THIS CHILD LAST HAVE A COMPLETE PHYSICAL EXAMINATION?
DATE:_____REASON_____
13. WHO IS THE PEDIATRICIAN OR FAMILY PHYSICIAN FOR THIS CHILD?_____

COMMENTS: EXPLANATIONS MUST BE GIVEN FOR EACH "YES" ANSWER_____
_____
_____
_____

TO BE COMPLETED AFTER EXAMINATION:

I AUTHORIZE THE ATTENDING DENTIST TO COMPLETE ALL NECESSARY TREATMENT THAT WAS PLANNED AND DISCUSSED WITH ME.

DATE:_____ SIGNATURE:_____