# HEALTH HISTORY

______________________________________________________________________________

Patient's Name | Birthdate | Sex | Race

______________________________________________________________________________

Pediatrician's Name | Pediatrician's Phone Number

Please check yes or no to the following questions:

| Yes | No | |
|---|---|---|
| ( ) | ( ) | Are your child's immunizations/shots up to date? If not, reason:___________________________________ |
| ( ) | ( ) | Has your child ever been admitted to a hospital? Reason:__________________________________________ |
| ( ) | ( ) | Has your child ever been a patient in an emergency room? Reason:___________________________________ |
| ( ) | ( ) | Has your child ever had any surgeries/operations? Reason:__________________________________________ |
| ( ) | ( ) | Has your child ever had any serious illnesses/injuries? Specify:______________________________________ |
| ( ) | ( ) | Does your child have any allergies to medicines, latex, environment or foods? Specify:___________________ |
| ( ) | ( ) | Is your child currently taking any medications? |

Medication_________________________ dosage______ times per day_____ reason____________________

Medication_________________________ dosage______ times per day_____ reason____________________

Medication_________________________ dosage______ times per day_____ reason____________________

( ) ( ) Does your child take birth control pills?

Please check if your child has (had) any of the following medical conditions:

| | | |
|---|---|---|
| ( ) Acid Reflux | ( ) Diabetes | ( ) HIV/AIDS |
| ( ) ADD/ADHD | ( ) Digestive Problems | ( ) Kidney Disease |
| ( ) Anemia | ( ) Epilepsy/Seizures | ( ) Learning Disability |
| ( ) Asthma | ( ) Eye Problems | ( ) Liver Disease |
| ( ) Autism | ( ) Emotional Disorder | ( ) Muscular Dystrophy |
| ( ) Bleeding Disorder | ( ) Fainting/Dizziness | ( ) Orthopedic Problems |
| ( ) Brain Injury | ( ) Genetic Disorder | ( ) Rheumatic Fever |
| ( ) Cancer/Tumor | ( ) Hearing/Speech Problems | ( ) Sleep Apnea |
| ( ) Cerebral Palsy | ( ) Heart Murmur | ( ) Tonsil Problems |
| ( ) Down Syndrome | ( ) Heart Problems | ( ) Tuberculosis |
| ( ) Developmental Delay | ( ) Hepatitis | |

To the best of my knowledge, the above health and dental history information is as accurate as possible. Should any changes occur in my child's health, I will promptly inform Dr. Bajjalieh.

___________________________________________ ______________________________________________

Patient/Parent's signature Date | Michelle Bajjalieh, DMD Date

Periodic Update ___________________________________________________________________________

Periodic Update ___________________________________________________________________________

# DENTAL HISTORY

_______________________________________________________________

Patient's Name                                                 Birthdate

Please check yes or no to the following questions:

Yes No

( ) ( ) Has your child ever been seen by a dentist? If yes, who? ________________________________________

( ) ( ) Do you feel that your child will be a cooperative patient?

( ) ( ) Does your child play any sport activities? If yes, does he/she wear a mouthguard? ______

( ) ( ) Has your child ever fallen and hit his/her tooth/mouth/head?

( ) ( ) Does your child have any oral habits such as finger sucking, pacifier, nail biting, grinding, etc.?

( ) ( ) Does your child snore heavily or is an exclusive mouth breather?

( ) ( ) Does your child brush his/her teeth daily? How often? _________________

( ) ( ) Does your child floss his/her teeth daily?

( ) ( ) Do you assist your child with brushing/flossing?

( ) ( ) Is your community water supply fluoridated?

( ) ( ) Does your child take any vitamins with fluoride or fluoride supplements?

( ) ( ) Does your child go to sleep with a bottle or sippy cup? If yes, what do you put in it? ___________________

( ) ( ) Are you currently breastfeeding your child? How often? ________________________________________

To the best of my knowledge, the above health and dental history information is as accurate as possible. Should any changes occur in my child's health, I will promptly inform Dr. Bajjalieh.

______________________________________        ________________________________________

Patient/Parent's signature        Date        Michelle Bajjalieh, DMD        Date

Periodic Update _________________________________________________________________

Periodic Update _________________________________________________________________

**Whom may we thank for referring you?**

Friend/Family Member ______________________ Insurance Company _____________________

Internet_____________________ Pediatrician ___________________

Dentist________________________