PEDIATRIC HEALTH HISTORY FORM

Patient Name:_____ **Prefers to Be Called:**_____ **Date of Birth**_____
Last, First, Middle Initial First Month/Day/Year

YES NO Does the patient have any of the following conditions?

- ☐ Low blood counts that require child to wear a mask
- ☐ Persistent cough greater than 3 weeks OR a cough that produces blood
- ☐ Been exposed to or have Tuberculosis

*****If you answered yes to the question above please stop. Please speak to the reception desk for further instructions*****

STATUS OF MEDICAL CARE INFORMATION:

Who is the patient's primary medical doctor? _____

Primary Medical Doctor: Address _____Phone: _____

YES NO Has the patient received care in the last year for a medical, emotional, developmental, or behavioral condition?

YES NO Are any of the patient's doctors affiliated with University of Minnesota Health, University of Minnesota Children's Hospital, University of Minnesota Physicians, or Fairview Health Services and Clinics?

YES NO Has the patient had surgery or operations, emergency department visits, or overnight stays in the hospital?

YES NO Is the patient vaccinated against common childhood infections?

YES NO Is the patient currently pregnant?

MEDICAL CONDITIONS:

YES NO Does the patient have a <u>past history</u> or <u>a current disease, problem, or condition</u> involving any of the following?

If yes, check all that apply.

- ☐ Behavior , Emotions , or Mental health
- ☐ Birth Defects or Syndrome
- ☐ Blood or Bleeding
- ☐ Bones, Joints, or Connective Tissues
- ☐ Brain or Spinal Cord
- ☐ Complications Before or During Birth
- ☐ Intellectual or Developmental Disabilities
- ☐ Eating, Swallowing, Diet, Nutrition, or Digestion
- ☐ Exercise or Body Movement
- ☐ Head, Eyes, Ears, Nose, or Throat
- ☐ Hormones or Pregnancy
- ☐ Heart or Blood Vessels
- ☐ Height or Weight
- ☐ Infections or Immune System
- ☐ Kidneys or Urinary Tract
- ☐ Liver, Stomach, or Intestines
- ☐ Lungs, Airway, or Breathing
- ☐ Muscles, Nerves, or Reflexes
- ☐ Senses or Sensory problems
- ☐ Speech or Language
- ☐ Skin or Glands

☐ Please describe the checked condition(s) above or provide information about any disease, problem, or condition not listed above

ALLERGIES:

YES NO Does the patient have allergies or develop a reaction to medications, foods, or environmental allergens? If yes, please specify:

Allergic To: 1) _____ Reaction: 1) _____

Allergic To: 2) _____ Reaction: 2) _____

Allergic To: 3) _____ Reaction: 3) _____

MEDICATIONS, VITAMINS, DIET SUPPLEMENTS, OR NATURAL/HERBAL PRODUCTS:

YES NO Does the patient take medications, diet supplements, vitamins, or natural or herbal products?

Medications, Vitamins, Diet Supplements, or Natural/Herbal Products	How Much / When

TOBACCO AND RECREATIONAL DRUG USE:

YES NO Does the patient use or has used tobacco (smoking, snuff, chew, bidis)?

YES NO Does the patient use or has the patient used prescription or street drugs or other substances for recreational purposes?

To the best of my knowledge, the answers I have given are accurate. I agree to report changes in the patient's medical status to the dentist, I give the dentist permission to obtain additional information about the patient's medical history from the patient's physician as is needed to provide dental treatment.

Person Completing this Form: Signature: _____Relationship to Patient:_____ Date: _____

YES NO Interpreter/Translator Name: Print Name:_____Signature: _____