Dr. Juei Kao **PEDIATRIC DENTISTRY**

HEALTH & DENTAL HISTORY

Jan 2015

Patient's Name (first, last): _____

Date of Birth: _____ Gender: _____

Patient's Physician: _____ Phone: _____

Specialist: _____ Phone: _____

IS / HAS CHILD:

Any illness now?	Yes	No
Receiving any medications or drugs?	Yes	No
Ever been hospitalized?	Yes	No
Ever had surgery?	Yes	No
Allergic to any medications?	Yes	No
Allergic to latex products?	Yes	No
Any food or dye allergies?	Yes	No

IF YES:

Type: _____

List: _____

Date: _____

Date: _____

List: _____

List: _____

List: _____

HAS CHILD ANY HISTORY OF:

Acid Reflux	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Hearing Problem	Yes	No	Sleep Apnea	Yes	No
Asthma	Yes	No	Heart Problem	Yes	No	Tuberculosis	Yes	No
Autism	Yes	No	Heart Murmur	Yes	No	Tumors / Cancer	Yes	No
Bleeding Disorder	Yes	No	Hepatitis	Yes	No	Special Needs / Other:		
Diabetes	Yes	No	HIV / AIDS	Yes	No			
Eating Disorder	Yes	No	Kidney Disease	Yes	No			
Emotional Problem	Yes	No	Liver Disease	Yes	No			
Epilepsy/Convulsions	Yes	No	Mental Disorder	Yes	No			

Reason for this appointment: _____

Date of last dental visit: _____ For what service? _____

Do you have any questions or concerns about your child's oral health? _____

DENTAL HISTORY:

Is Fluoride taken in any form?	Yes	No
Adverse reaction to anesthetics?	Yes	No
Oral Habits (thumb, pacifier...)	Yes	No
Past injury to mouth, teeth or head?	Yes	No
Family history of cavities?	Yes	No
Family history of braces?	Yes	No
Does your child snack frequently?	Yes	No
Is your child on a special diet?	Yes	No

IF YES, PLEASE EXPLAIN:

_____

_____

_____

_____

_____

_____

_____

_____

Parent / Guardian Signature: _____ Date: _____

Reviewed by (signature): _____ on: _____

Juei Kao, DMD 7455 El Camino Real, Ste. K • Daly City, CA 94014 • tel: (650) 755-0277 • fax: (650) 755-3158 • info@jueikaodmd.com