Ambulatory Dental Anesthesia of Montana

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Children's Health Questionnaire

Chart ID: ______________

▲Child's name: ____ ▲Nickname____________________
First MI Last

▲Sex: __Male __Female ▲Birthdate: ___/___/___

▲Child's interests: ______________________________________▲Name of pet: ____________________________

▲Child's attitude towards dental care: ____

▲Does your child have any special needs? If so, what? ____

▲Child's learning: __Slow __Average __Accelerated

▲Name of child's dentist: ____ Phone: (_____) ___________________

Health History

▲Last physical: ___/___/___ Weight: ________ Height: _______

▲Name of Pediatrician: ____ Phone: (_____) _________________

▲Is your child under the care of a pediatrician now? Yes / No ▲ Reason: ____

▲Is your child taking any medications or drugs? Yes / No ▲ What kind? ____

▲Has your child ever been hospitalized? Yes / No ▲Reason: ____

▲Is your child allergic to any medications? Yes / No ▲ Please list: ____

▲Has your child ever had a reaction to: __eggs __soy __pollen __dust ___latex __foods __animals __other

▲Has your child had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
_____	_____	Premature birth	_____	_____	Earaches	_____	_____	Speech disorder	_____	_____	Nose bleeds
_____	_____	Heart problems	_____	_____	Kidney problems	_____	_____	Hearing impaired	_____	_____	Asthma
_____	_____	Seizures	_____	_____	Bleeding problems	_____	_____	Brain injury	_____	_____	Liver problems
_____	_____	Immune disorder	_____	_____	Cerebral Palsy	_____	_____	Bruises easily	_____	_____	Bone disorders
_____	_____	Medication allergy	_____	_____	Anemia	_____	_____	Bladder problems	_____	_____	Rheumatic fever
_____	_____	Diabetes	_____	_____	Motion sickness	_____	_____	Fainting/dizziness	_____	_____	Cancer/malignancies
_____	_____	Hepatitis	_____	_____	Delayed development	_____	_____	Emotional problems	_____	_____	Tuberculosis
_____	_____	Autism	_____	_____	ADD/ADHD	_____	_____	School problems			

▲Please provide any additional detail necessary below:

____
____
____
____
____
____
____

▲How may I help to make this visit a positive experience for your child? ____
____

▲Father (full name) ____

▲Mother (full name) ____

▲Parents are: ___Single ____Married ____Divorced

▲___Child lives with both parents ____Child lives with mother ____Child lives with father

▲___Child lives with legal guardian other than parent ▲Name: ____

▲Home address: ____ Phone: (_____) ______________

Street City State Zip

Your child is incredibly special to you, as well as me. By signing below, you are stating that all of the above information is correct to the best of your knowledge. Information that is not fully correct can have negative consequences on your child.

▲Signature: __________________________________ Relationship: ______________ Date: ___/___/___

Reviewed by:

▲Signature: __________________________________ Date: ___/___/___

Terry Klise, DDS