JOHN E. WHITE, D.D.S., STEPHEN J. RANEY, D.M.D.

PEDIATRIC HEALTH QUESTIONNAIRE

Date_____

Patient's name_____Sex_____Weight_____

Home address_____

Parent/legal guardian name(s)_____

Parent/legal guardian address(if different than patient)_____

Home phone_____Parent/guardian work or cell phone_____

Birth date_____Age_____

1. Has your child been hospitalized or under the care of a physician within the last 2 years? _____
2. Has there been a change in your child's general health within the past 2 years? _____
3. Is your child allergic to penicillin, latex or anything else? _____
4. Indicate **Yes** or **No** to any of the conditions below which your child has had:

Y / N	Cerebral Palsy	Y / N	Hives, skin rash	Y / N	Substance abuse
Y / N	Heart trouble	Y / N	Cancer treatment	Y / N	Allergies
Y / N	Heart surgery	Y / N	Radiation therapy	Y / N	HIV infection
Y / N	Rheumatic heart disease	Y / N	Ulcers	Y / N	Diabetes
Y / N	Blood pressure problems	Y / N	Gastritis	Y / N	Hepatitis
Y / N	Prolapsed mitral valve	Y / N	Arthritis	Y / N	Kidney trouble
Y / N	Heart murmur	Y / N	Easy bruising	Y / N	Psychiatric treatment
Y / N	Artificial heart valves	Y / N	Excessive bleeding	Y / N	Fainting spells
Y / N	Congenital heart lesions	Y / N	Persistent Cough	Y / N	Seizures
Y / N	Hearing/vision impaired	Y / N	Bronchitis	Y / N	Epilepsy
Y / N	Mental Retardation	Y / N	Asthma	Y / N	Anemia
Y / N	Attention Def. Disorder	Y / N	Learning disability		

5. Has your child had any serious illness, disease, or condition not listed above? _____
   If so, explain _____
   _____
6. Indicate date of your child's last physical examination _____
7. Name and address of your child's physician _____
   _____
8. List any medications your child is currently taking _____
   _____
9. Has your child had any behavioral problems or anxiety associated with previous dental care?
   If so, explain _____
   _____
   _____

continue on reverse

Indicate Yes or No To The Following.	**CHECK ONE**	**YES**	**NO**

10. Does your child have any history of thumb sucking, tongue thrusting, lip biting , fingernail biting, mouth breathing, gagging, vomiting? ____ ____
    (If yes, underline, and explain)
    _____

11. Do you consider your child to be high-strung or generally nervous? ____ ____

12. Is there anything you wish to tell us that has not been asked?

13. Were there any items you did not understand?

Signature of person completing form: _____

Circle Relationship parent guardian

Date signed:_____