Patient Name: ____ Today's Date:___________________

PATIENT HISTORY

Please answer the following questions about your child.

What was your child's birth weight? ____

Did your child need newborn intensive care?____

Has your child spent the night in the hospital (other than as a newborn) _______________________

Has your child had any surgeries?____

Is your child allergic to any medications?____

Is your child currently taking fluoride?____

Is your child taking other medications on a regular basis?_____________________________________

Does your child have any chronic health conditions?____

SOCIAL HISTORY

Please answer the following questions about your child's social history.

Where does your child spend most weekdays?____

How many adults live in your home?____

Do the parents of this child live separately?____

How many children live in your home?____

Does anyone living in your home smoke?____

Does your family follow any special diet?____

Is there anything else you would like us to know?____