



**THE DENTAL ROAD CREW  
MOBILE DENTAL PROGRAM  
HEALTH HISTORY**



Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Room Number \_\_\_\_\_

1. When was your child's last visit to the dentist? \_\_\_\_\_

2. Has your child had heart surgery?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

3. Has your child had any other serious health problems?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

4. Does your child take any medication?  Yes  No

If yes, please list \_\_\_\_\_

5. Is your child allergic to any medications or drugs?  Yes  No

If yes, please list \_\_\_\_\_

6. Has your child ever had problems during or after a visit to the dentist?  Yes  No

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

7. Has your child had any of the following:

- |                     |                              |                             |                   |                              |                             |
|---------------------|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|
| Diabetes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (TB) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Trouble    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach Ulcers    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hives             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nervous Disorder    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Disease     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/Aids            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ADD/ADHD            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____       |                              |                             |
- (Attention Deficit Disorder)

◆◆ Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_