Patient Health Questionnaire

Thank you for helping us get to know your child through their health and dental histories.

Please feel free to ask us if you have any questions.

We hope you have a wonderful experience with us!

Aloha, ToothBuds

Today's Date_____________

Patients Full Name ____ Age______ Sex_______ Date of Birth____________________

Your Child's Physician's Name______________________________________ City________________ Physician's #____________________

What is your biggest concern or question for us? ____

	YES	NO
1. Is this patient experiencing pain/discomfort/swelling or toothaches? (circle one)	1. _____	_____
2. Is this the first dental visit **ever** for this patient?	2. _____	_____
3. Is this patient under treatment by a physician for a particular medical condition?	3. _____	_____
4. Is this patient taking any medications or supplements? If so, please kindly list: i. ____________________________	4. _____	_____
5. Has this patient ever been seriously sick, hospitalized, or had surgery?	5. _____	_____
6. Has a physician ever told you that this patient has a heart murmur?	6. _____	_____
7. Is this patient physically, mentally, or emotionally disabled?	7. _____	_____
8. Does this patient have a learning disability?	8. _____	_____
9. Has this patient ever had a history of any of the following listed below? a. If **YES,** check the appropriate spaces. If **NO,** check here ----------------------→	9. _____	_____

___ Anemia ___ Kidney or Liver Disorders

___ Asthma ___ Child Diseases (mumps, measles)

___ Bleeding Disorders ___ Sezures/ Epilepsy

___ Diabetes ___ Tuberculosis

___ Heart Disorders ___ Infectious Diseases

___ Hepatitis ___ ADHD

___ Autism ___ Other: ____

10. Is this patient allergic to any medications or products?
    ____
11. Please check if this patient ever had any history of the following oral habits:

    ___ Pacifier ___ Thumb/Finger Sucking ___ Mouth Breathing ___ Teeth Grinding ___ Nail Biting

    ___ Tobacco Use ___ Other: ____
12. Please list any significant trauma to the face or jaw: ____
13. **FOR OUR TEENAGE PATIENTS:** Is this patient pregnant? If yes, when is the due date? _____________________

Oral Hygiene Questions:

How many times does your child brush per day? _______________

How many times does your child floss per day? _______________

Does your child us fluoride rinse or supplements? _______________

Parent or Guardian Printed Name __________________________________ **Signature** ____