Patient's name:_______________________________ Date: _______Chart#:___________

ETHNIC ORIGIN OF MOTHER: (Circle only one; to be used for program funding information) Chamorro, Filipino, Caucasian, African American, Chinese, Japanese, Vietnamese, Korean, Chuukese, Kosrean, Marshallese, Palauan, Pohnpean, Yapese, Other__________

For Dental Use Only:

MEDICAL ALERT	ALLERGIES	MEDICATIONS

A. CHILD'S HEALTH HISTORY

Circle Answer

1. Is your child in good health?... Yes No
2. Is your child allergic to anything?.. Yes No
3. Is your child receiving any medical treatment now?..................... Yes No
4. Is your child taking any medication now?................................. Yes No
5. Has a physician ever informed you that your child has

   a. Asthma.. Yes No
   b. Heart murmur.. Yes No
   c. Heart problem... Yes No
   d. High blood pressure... Yes No
   e. Diabetes .... Yes No
   f. Lung disease.. Yes No
   g. Rheumatic fever... Yes No
   h. Any blood disease... Yes No
   i. Any bleeding tendency... Yes No
   j. Kidney disease.. Yes No
   k. Glaucoma.. Yes No
   l. Tuberculosis.. Yes No
   m. Hepatitis or liver disease...................................... Yes No
   n. Epilepsy (Seizures)... Yes No
   o. Cancer.. Yes No
   p. Any other medical problems or treatment not listed.......... Yes No

6. Has your child ever been hospitalized?.................................... Yes No
7. Has your child ever had a fractured jaw?.................................. Yes No
8. Is your daughter pregnant or nursing?..................................... Yes No
9. Is your daughter taking birth control pills?.............................. Yes No

Please explain all "yes" answers:____

____

B. CHILD'S DENTAL HISTORY

		Circle answer
1.	Does your child brush daily?...	Yes No
2.	Does your child use floss?..	Yes No
3.	Has your child ever had problems with the local anesthesia?............	Yes No
4.	Has your child ever had problems with prior dental treatment?.........	Yes No
5.	Does your child's gums bleed easily?......................................	Yes No
6.	Does your child have any toothaches or dental problems at the present time?...	Yes No
7.	When was your child's last dental check-up?____________	

Please explain all "yes" answers:____

____

C. AUTHORIZATION

To the best of my knowledge, I have answered every question completely and accurately. I understand it will be held in the strictest of confidence and it is my responsibility to inform the Department of Public Health and Social Services (DPHSS) Dental Section of any changes in my child's medical status and/or medication. I authorize the DPHSS Dental Staff to perform the necessary dental services for my child.

______________________________ ______________

PARENT'S/GUARDIAN'S SIGNATURE DATE

****************DO NOT WRITE BELOW**************

D. HISTORY REVIEW

History Reviewed by the Dentist (Dentist's initials)__________________Date_________

E. UPDATE (Completed at follow-up visits)

No changes in patient's health since last dental visit. Initials__________Date________

No changes in patient's health since last dental visit. Initials__________Date________