Sonoma County Indian Health Project, Inc.
Pediatric Health History Form

Child's Physician: _____ Address: _____ Phone: _____

Date of last physical Exam: _____ Results: _____

MEDICAL HISTORY

Question	Yes	No	Question	Yes	No
Is the child under care of a physician now	☐	☐	Does the child have a heart murmur or any heart problems	☐	☐
Is the child taking any medications or drugs	☐	☐	Are there any emotional problems	☐	☐
Has the child every been hospitalized	☐	☐	Are there any serious medical or physical problems		
Has child ever had asthma or lung problems	☐	☐	***Summary (For Doctor's use only)***		
Is there any allergy to penicillin or other drugs	☐	☐			

Has child a history of or difficulty with any of the following:							
☐	Anemia	☐	Cerebral Palsy	☐	Hearing Impairment	☐	Liver Disease
☐	Abnormal Bleeding	☐	Chronic Sinus Infections	☐	Hemophilia	☐	Learning Disabilities
☐	Allergies to Foods	☐	Congenital Heart Defect	☐	Hepatitis	☐	Rheumatic Fever
☐	Allergic to Latex	☐	Developmental Delay	☐	High Fevers	☐	Seizures or Epilepsy
☐	Blood Transfusions	☐	Diabetes	☐	HIV+/AIDS	☐	Sickle Cell Disease
☐	Breaths only through mouth	☐	Ear Infections	☐	Hyperactive/ADD	☐	Tuberculosis (TB)
☐	Cancer	☐	Handicaps or Disabilities	☐	Kidney Disorder	☐	Vision Impairment

DENTAL HISTORY

Question	Yes	No	Question	Yes	No
Has child been to dentist before Date of that visit:			Does child brush teeth daily		
Does child have any dental problems at present time			Do you assist with tooth brushing		
Any unhappy dental or medical experiences			Is dental floss used		
Does child suck a ☐Thumb ☐Finger ☐Pacifier			Any injuries to mouth or teeth		
Does child grind teeth or clench jaws			Is fluoride taken in any form ☐Tablets ☐Drops ☐Water		
Does child currently use a bottle			Child's attitude toward dentistry		
Does child currently nurse			Reason for today's visit		
Name of Parents' Dentist					

Consent to Treat Minor

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the dental staff at SCIHP of any changes in my child's health status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature: _____ Date: _____
Parent or Legal Guardian

Print Name: _____

SCIHP Office Use Only

Please Print!

Examining Doctor's Name: _____ Date: _____