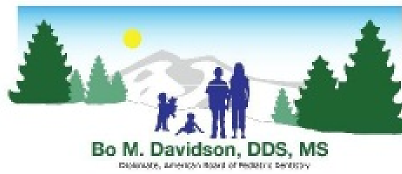
Hawks Prairie Pediatric Dentistry
130 Marvin Road SE Suite 111
Lacey, Wa 98503
Phone (360)489-1406 Fax (360)491-1270



West Olympia Kids Dentistry
405 Cooper Point Road Suite 104
Olympia, Wa 98502
Phone (360) 688-7909 Fax (360) 352-2684

Patient First Name: ☐ Last Name: ☐ Birthdate: ☐

Health History

Indicate which of the following conditions your child has now or ever has had:

Condition	Yes	No	Condition	Yes	No
ADD/ADHD	☐ Yes	☐ No	Hepatitis A,B,C (explain below)	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hydrocephalus	☐ Yes	☐ No
Arthritis or joint problems	☐ Yes	☐ No	Immune Deficiency	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Learning Disability	☐ Yes	☐ No
Behavioral Problems	☐ Yes	☐ No	Liver/GI Disease	☐ Yes	☐ No
Birth Defects/Hereditary Problems	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Bleeding Issues	☐ Yes	☐ No	Measles/Mumps	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Bone Disease	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Brain Injury	☐ Yes	☐ No	Psychiatric/Psychological Disorder	☐ Yes	☐ No
Bruising Issues	☐ Yes	☐ No	Reflux	☐ Yes	☐ No
Cancer/Tumors	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Chemotherapy/Radiation	☐ Yes	☐ No	Seizures/Epilepsy	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
Developmental Delay	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
Diabetes or low sugar	☐ Yes	☐ No	Significant Injury	☐ Yes	☐ No
Endocrine problems	☐ Yes	☐ No	Skin Disorder	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No	Speech Disorder	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Heart Defects	☐ Yes	☐ No	Vision Impairment	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Other	☐ Yes	☐ No
Heart Valve Replacement	☐ Yes	☐ No			

Please Explain if other or answered yes to above questions:

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I have read the above questions and understand them. I will not hold my pediatric dentist or any member of his/her staff responisble for any error or omissions that I have made in the completion of this form. I will notify my pediatric dentist of any chages in my child's medical or dental health.

Parent/Guardian Signature: Date: