Celebrate Smiles
Access Community Health Centers

CELEBRATE SMILES HEALTH HISTORY FORM

Please answer the questions below about your child:

1. **Does your child have any allergies (i.e., medicines, food latex, etc.)?**

   ☐ Yes ☐ No

   If yes, what type? _____

2. **Has your child been seen by a dentist?**

   ☐ Yes, within one year

   ☐ Yes, over one year ago

   ☐ Never

Name of your child's dentist: _____

3. **Does your child use medicine prescribed by a doctor?**

   ☐ Yes ☐ No

If yes, what kind? _____

4. **Does your child need or use more medical care than other children the same age?**

   ☐ Yes ☐ No

5. **Does your child have trouble doing things most children the same age can do?**

   ☐ Yes ☐ No

6. **Does your child need or get special therapy, such as physical therapy, occupational therapy, or speech therapy?**

   ☐ Yes ☐ No

7. **Does your child need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking, or activities other children the same age can do?**

   ☐ Yes ☐ No

   If you selected "yes" to questions 3-7 above, please answer the below question:
   Has this problem lasted or is expected to last at least 12 months?

   ☐ Yes ☐ No

Is there anything else about your child you would like us to know?