Child's name: ______________________
Child's Pediatrician/Physician: ______________________ Phone: ______________________

MEDICAL HISTORY	
Growth and Development	
Any learning, behavioral, excessive nervousness or communication problems?	☐ No ☐ Yes
Has child had psychological counseling or is counseling being considered for the near future?	☐ No ☐ Yes
Were there any complications during pregnancy or was child premature at birth?	☐ No ☐ Yes
Any problems with physical growth?	☐ No ☐ Yes
Respiratory System	
Any history of pneumonia, cystic fibrosis, asthma, shortness of breath or difficulty in breathing?	☐ No ☐ Yes
Cardiovascular System	
Any history of congenital heart disease, heart murmur, or heart damages from rheumatic fever?	☐ No ☐ Yes
Has any heart surgery been done or recommended?	☐ No ☐ Yes
Any history of chest pains or high blood pressure?	☐ No ☐ Yes
Central Nervous System	
Any history of cerebral palsy, seizures, convulsions, fainting or loss of consciousness?	☐ No ☐ Yes
Any history of injury to the head?	☐ No ☐ Yes
Any sensory disorders?	☐ No ☐ Yes
Genitourinary System	
Any history of urinary tract infections, bladder or kidney problems?	☐ No ☐ Yes
Is the patient pregnant or possibly pregnant?	☐ No ☐ Yes
Extremities	
Any limitations of use of arms or legs?	☐ No ☐ Yes
Any arthritis, joint bleeding, joint replacement, or other joint problems?	☐ No ☐ Yes
Any problems with muscle weakness or muscular dystrophy?	☐ No ☐ Yes
Skin	
Any history of skin problems?	☐ No ☐ Yes
Any history of cold sores (herpes) or canker sore (aphthae)?	☐ No ☐ Yes
Hematopoietic and Lymphatic System	
Has your child ever had a blood transfusion?	☐ No ☐ Yes
Any history or anemia or sickle cell disease?	☐ No ☐ Yes
Does you child bruise easily, have frequent nosebleeds, or bleed easily from small cuts?	☐ No ☐ Yes
Gastrointestinal System	
Any history of stomach, intestinal or liver problems?	☐ No ☐ Yes
Any history of hepatitis or jaundice?	☐ No ☐ Yes
Any history of eating disorder, such as anorexia nervosa or bulimia?	☐ No ☐ Yes
Any history of unintentional weight loss?	☐ No ☐ Yes
Endocrine System	
Any history of diabetes?	☐ No ☐ Yes
Any history of thyroid disorders or other glandular disorders?	☐ No ☐ Yes
Medications	
Is your child currently taking any medications (prescription or non prescription medicine)?	☐ No ☐ Yes
If yes, what?	

1. Is your child's general health good at this time? ☐ Yes ☐ No

2. Is this the first dental visit? ☐ Yes ☐ No Previous Dentist ____________________________
Date of last visit? ___________ Reason for visit? ___________________ Date of last x-rays? ___________

3. What concerns you most about your child's teeth? ____

4. Does your child ever have any dental pain? ☐ Yes ☐ No
If yes, please describe____

5. Has your child experienced any negative medical or dental care? ☐ Yes ☐ No
If yes, please describe____

6. How would you describe your child's temperament? ____
How do you think your child will react to dental treatment? _______________________________________

7. Does your child have any following habits? ☐ Thumb/Finger sucking ☐ Nail biting ☐ Lip sucking
☐ Tooth grinding ☐ Pacifier ☐ Mouth breathing ☐ Nursing bottle ☐ Nursing at bedtime ☐ Sippy cup
☐ None ☐ Other_________________________________

8. How often does your child brush per day? _________ Who brushes your child's teeth? __________________

9. Has the child received any fluoride treatment? ___________

10. Have your child's teeth ever been injured? ☐ Yes ☐ No
If yes, please describe____

MEDICAL INFORMATION

1. Is a physician treating your child now for a specific illness? ☐ Yes ☐ No
If so, please explain____

2. Is your child allergic to anything (medicine, food)? ☐ Yes ☐ No
If so, please list____

3. Has your child ever been hospitalized? ☐ Yes ☐ No
If so, when and why?____

4. Are all immunizations up to date? ☐ Yes ☐ No

5. Please check any of the following that your child has now or has been exposed to in the past:
☐ HIV/AIDS ☐ Lead Poisoning ☐ Tuberculosis ☐ Substance Abuse
☐ Leukemia ☐ Child Abuse

6. Is there anything else regarding your child's physical, mental or emotional health that you feel we should know about? ☐ Yes ☐ No
If so, please describe____

I acknowledge that the information provided on this form is accurate. I hereby give permission to Pleasant Pediatric Dentistry to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but is not limited to, topical and local anesthetic (injections), voice control and radiographs (x-rays). Whoever accompanies this child on subsequent visits has my express permission to consent to treatment.

Signature of Legal Guardian____ **Date**_______________