

MEDICAL HISTORY

- 1) Was your child premature? Yes No
- 2) Were there any difficulties during the pregnancy, delivery, or first year of life? Yes No
 a) Explain _____
- 3) Is a physician treating your child now for a specific illness? Yes No
 a) Explain _____
- 4) Is your child taking any medications at this time? Yes No

DRUG	DOSE	FREQUENCY	REASON

- 5) Has your child taken any medication in the past? Yes No
 a) Explain _____
- 6) Has your child had any allergies or unusual reactions to the following?
 a) Medications Yes No Foods Yes No Latex Yes No
 b) Other Yes No Explain _____
- 7) Has your child ever been hospitalized? Yes No
 a) Explain _____
- 8) Has your child ever have an operation? Yes No
 a) Explain _____
 b) Was general anesthesia used? Yes No
 i) Any complications? Yes No
 ii) Explain _____
- 9) Are your child's immunizations up-to-date? Yes No

10) Has your child ever been diagnosed with any of the following conditions? Please check **yes or no**.

- | | | |
|--|--|---|
| <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Autism</p> <p><input type="checkbox"/> <input type="checkbox"/> Bladder Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood transfusions</p> <p><input type="checkbox"/> <input type="checkbox"/> Birth defects</p> <p><input type="checkbox"/> <input type="checkbox"/> Bone or joint problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Brain injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruising easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer or malignancies</p> <p><input type="checkbox"/> <input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic adenoid / tonsil</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic ear infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Cleft lip/palate</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Convulsions / Seizur</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional disturbances</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive bleeding problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive gagging</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting or dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Growth and Dev. Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing / speech problems</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis or liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Hyperactivity</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental retardation</p> <p><input type="checkbox"/> <input type="checkbox"/> Nutritional deficiency</p> <p><input type="checkbox"/> <input type="checkbox"/> Oral ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Orthopedic problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Premature birth</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle cell anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Syndrome _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
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DENTAL HISTORY

- 1) Please check reason(s) for seeking dental care
- | | | |
|--|--|--|
| <input type="checkbox"/> First Examination | <input type="checkbox"/> Routine Check-up | <input type="checkbox"/> Toothache or swelling |
| <input type="checkbox"/> Appearance of teeth | <input type="checkbox"/> Crowding of teeth | <input type="checkbox"/> Accident |
- Other _____
- 2) Has your child been to a dentist previously? Yes No
- a) When was the last visit? _____
- b) Have x-rays been taken? Yes No When? _____
- c) How would you describe your child's temperament?
- | | | | | | |
|-----------------------------------|--------------------------------|-----------------------------------|----------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Shy | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Anxious | <input type="checkbox"/> Frightened | <input type="checkbox"/> Regular Kid |
| <input type="checkbox"/> Curious | <input type="checkbox"/> Moody | <input type="checkbox"/> Friendly | <input type="checkbox"/> Defiant | <input type="checkbox"/> High Strung | <input type="checkbox"/> Cooperative |
- 3) How do you think your child will react to dental treatment? _____
- 4) Does your child have fluoride in any of the following forms?
- a) Toothpaste Yes No Brand _____
- b) Drinking Water Yes No
- c) Topical Application Yes No
- d) Fluoride Tablets Yes No (0.25 mg / 0.5 mg / 1.0 mg)
- 5) Does your child brush his / her **own** teeth? Yes No
- a) When? AM PM After Snacks Before Bed After Breakfast
- 6) Do **you** brush your child's teeth? Yes No
- a) When? AM PM After Snacks Before Bed After Breakfast
- 7) Do **you** or **your** child use dental floss in cleaning your child's teeth? Yes No
- a) When? AM PM After Snacks Before Bed After Breakfast
- 8) Does your child have snacks in between meals? Yes No
- 9) Have your child's teeth ever been injured? Yes No
- 10) Does your child have any of the following habits?
- | | | |
|--|--|---|
| <input type="checkbox"/> Thumb or finger sucking | <input type="checkbox"/> Lip sucking or biting | <input type="checkbox"/> Bottle to bed at night |
| <input type="checkbox"/> Pacifier | <input type="checkbox"/> Mouth Breathing | |

I hereby give permission to Pediatric Dental Associates to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (injections), radiographs, etc.

Signature of legal guardian _____ Date _____