Since Your Child's Last Visit

Patient Name _____

Has your child taken any new medications?	No	Yes	If yes, explain
Has there been any change in insurance eligibility?	No	Yes	If yes, explain
Has there been any change in contact information?	No	Yes	If yes, explain
E-mail address			
Daytime Contact phone number			

GROWTH AND DEVELOPMENT	Any problems with physical growth?	No	Yes
	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
CENTRAL NERVOUS SYSTEM	Any sensory disorders?	No	Yes
	Any history of cerebral palsy, seizures, convulsions, fainting or loss of consciousness?	No	Yes
	Any history of injury to the head?	No	Yes
CARDIOVASCULAR SYSTEM	Any history of chest pains or high blood pressure?	No	Yes
	Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever?	No	Yes
	Has any heart surgery been done or recommended?	No	Yes
HEMATOPOIETIC AND LYMPHATIC SYSTEM	Has your child ever had a blood transfusion?	No	Yes
	Any history of anemia or sickle cell disease?	No	Yes
	Does your child bruise easily, have frequent nosebleeds, or bleed easily from small cuts?	No	Yes
RESPIRATORY SYSTEM			
	Any history of pneumonia, cystic fibrosis, asthma, shortness of breath or difficulty in breathing?	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 disorders, such as anorexia nervosa or bulimia?	No	Yes
	Any history of unintentional weight loss?	No	Yes
GENITOURINARY SYSTEM	Is the patient pregnant or possibly pregnant?	No	Yes
	Any history or urinary tract infections, bladder or kidney problems?	No	Yes
ENDOCRINE SYSTEM	Any history of diabetes?	No	Yes
	Any history of thyroid disorders or other glandular disorders?	No	Yes
SKIN	Any history of skin problems?	No	Yes
	Any history of cold sores (herpes) or canker sores (aphthae)?	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

MEDICATIONS

Is your child currently taking any medication (prescription or non-prescription)? No Yes

Drug	Dose	Frequency	Reason

1. Is your child's general health good at this time? No Yes
2. Is a physician treating your child now for a specific illness? No Yes If so, explain _____
3. Is your child allergic to any medications? No Yes If so, please list _____
4. Does your child have any allergies? No Yes If so, please describe _____
5. Has your child ever been hospitalized? No Yes
   If so, when? _____ For what reason? _____
6. Are all immunizations up to date? No Yes
7. Please check any of the following that your child has now or has been exposed to in the past

HIV/AIDS	No	Yes	Lead Poisoning	No	Yes	Tuberculosis	No	Yes
Leukemia	No	Yes	Substance Abuse	No	Yes	Child Abuse	No	Yes

8. Is there anything else regarding your child's physical, mental, or emotional health that your feel we should know? No Yes
   If so, please describe _____

I acknowledge that the information provided on this form is accurate. I hereby give permission to North Scottsdale Pediatric Dentistry 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), voice control and radiographs (r-rays). Whoever accompanies this child on subsequent visits has my express permission to consent to treatment. I understand there is a $35 charge for appointments not kept with less than 24 hours notice.

Signature of Legal Guardian _____ _____ **Date** _____