anesthesia for dentistry

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Medical History Form

Patient's Name _____
Last First Middle

Father's Name _____ Home Phone (_____)_____
Mother's Name _____ Work Phone (_____)_____
Address_____ Cell Phone (_____)_____
City_____ State _____ Zip_____

Date of Birth ____/____/_____ Sex: M F Best # to reach you _____

Who is your Dentist? _____

Who is your Doctor? _____ Phone (_____)_____

Date of last physical exam _____/_____/_____ Weight_____ Height_____

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Please list all medications with dosages your child is now taking (include prescribed medications and over-the-counter vitamins):

_____
_____

Does your child have any allergies?

No Yes Drugs_____
No Yes Foods_____
No Yes Other_____

For the following questions, please circle Yes or No. Your answers will be considered confidential.

1. Is your child in good health?..... Yes No

2. Has your child ever tested positive, or been presumed positive for COVID-19 ……... Yes No
   If yes, please list date of positive result_____

3. Has your child had any serious illness, operation, or been hospitalized?..... Yes No
   If yes, please explain_____

4. Has your child or any family member have any unexpected problems with anesthesia?..... Yes No
   If yes, please explain_____

5. Does your child have any of the following diseases or problems?
   a. Heart murmur…….. Yes No
   b. Congenital Heart Disease……..... Yes No
   c. Other heart conditions…….. Yes No
   If yes to any above, please explain_____

Please See Next Page

d. Asthma, sinus trouble, or hay fever …….. Yes No
e. Chronic cough…… Yes No
f. Does your child currently have a cold or flu?..... Yes No
g. Does your child snore?..... Yes No
If yes to any above, please explain _____

h. Any liver conditions…… Yes No
If yes, please explain_____
i. Any kidneys conditions…… Yes No
If yes, please explain_____
j. Seizure history……. Yes No
If yes, please explain_____
k. Developmental delay…… Yes No
l. Autism……. Yes No
m. Attention deficit/hyperactivity disorder…… Yes No
n. Down syndrome……. Yes No

6. Does your child have any disease, condition, or problem not listed above?..... Yes No
If yes, explain_____
_____

To the best of my knowledge, all of the preceding answers are true and correct.
If there is any change in my child's health, or if my child's medicines change,
I will inform my anesthesiologist at the earliest possible time.

_____
Signature of Patient or Guardian

_____
Date