

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 _____

=====

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