Medical History

Patient's Name:

Gender:
○Male○Female

Age:

Date of Birth:
Select Date

Parent's Name:

Child's height (if known):

Child's weight: **lbs**

Home #:

Work #:

Cell #:

Dentist:

Does your child take any medications? ○Yes ○No
Please list all medications your child is taking

Does anyone smoke in your child's home? ○Yes ○No

Allergies ○Yes ○No
If yes, please comment

Recent cold or a cough ○Yes ○No
If yes, please comment

Snoring, asthma, reactive airway or breathing problems ○Yes ○No
If yes, please comment

Heart trouble, murmur, or heart surgery ○Yes ○No
If yes, please comment

Surgery or hospitalizations ○Yes ○No
If yes, please comment

Problems or complications with anesthesia ○Yes ○No
If yes, please comment

Epilepsy, seizures or fainting ○Yes ○No
If yes, please comment

Cerebral palsy, developmental delay, autism or ADHD ○Yes ○No
If yes, please comment

Any other medical conditions? ○Yes ○No
If yes, please comment

I have received the IV Sedation Information papers. ○Yes○No

Today's Date December 8, 202

X

Signature Certificate

Document name: Medical History

Unique Document ID: 274C5DBC66CA0047A9587BD2C92FCC61E4A95B5A

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