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 April 26, 2024

X _____

Signature Certificate

Document name: Medical History

Unique Document ID: 274C5DBC66CA0047A9587BD2C92FCC61E4A95B5A

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