Patient Medical History

Patient's Name

Gender:	**Age:**	**Date Of Birth:**
Parent's Name:	**Child's Height (if known):**	**Child's Weight:**
Home #:	**Work #:**	**Cell #:**

Dentist:

Does your child take any medications?

Does anyone smoke in your child's home?

Allergies

Recent cold, cough or reactive airway

Snoring, asthma or breathing problems

Heart trouble, murmur, or heart surgery

Surgery or hospitalizations

Problems or complications with anesthesia

Cerebral palsy, Epilepsy, Seizures or Fainting

Developmental delay, Autism or ADHD

Any other medical conditions?

I have received the IV Sedation Information papers.

Today's Date December 8, 2021

Parent Name:

X ______________________

Signature Certificate

Document name: Patient Medical History

Unique Document ID: 8D3F93DDA3BC51AD5877B8593AF03A7B96605585

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July 22, 2021 8:56 pm EST	Patient Medical History Uploaded by Pediatric Dental Anesthesia Associates - billing@pediatricsedation.com IP 47.201.198.107

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