Signed Patient Medical History

PEDIATRIC DENTAL ANESTHESIA ASSOCIATES

Signed Patient Medical History

Has this patient or any other family members been a patient of PDAA previously?		
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?		
How many minutes is your drive from home to the dental office?		

Today's Date April 26, 2024

Parent Name:

X _____

Signature Certificate

Document name: Signed Patient Medical History

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