Ambulatory Dental Anesthesia of New York

Medical History Questionnaire

Parents, please take some time to fill this form and **fax it to 516-453-6005 or Email ADAofNY@gmail.com.** If additional space is needed please use back of form

Patient's Name:_____Date of Birth:_____/_____/_____ Age:_____Weight:_____lbs

Address:_____City:_____State:_____Zip_____

Parent's Names:_____Home:(_____)_____Cell:(_____)_____

Date of Scheduled Treatment:_____/_____/_____ Dentist Name: Dr._____Best Time To Call:_____

Please list any and all medications your child is taking (include vitamins, herbals, over the counter meds):_____

Does your child have any **ALLERGIES** to any **medications** or **foods** (please list)?_____

1. Is your Child healthy and overall in good health?_____ Yes No
2. Was your child full term or born prematurely? If yes, how many weeks?_____Any complications during birth?_____Did your child have a breathing tube?_____If yes, for how long?_____
3. Any major medical issues, surgeries, accidents, or hospitalizations within the last 10 years?_____Yes No

If yes to question 3 please list them:_____

4. Currently is your child under the care of a physican?_____ Yes No
5. Does your child have/had in the past any of the following heart diseases or complications?_____ Yes No

Circle that apply: Congenital Heart Defect (CHD), Murmurs, Malfunctioning Heart Vales, Pacemaker, Arrhythmias or irregular heart beats, Ventricular or Atrial Septal defects

6. Does your child have/had any cardiovascular (heart) complications_____Yes No

Circle that apply: Chest pain or cyanosis (turns blue) upon exertion, Shortness of breath on exertion, High Blood Pressure, Stroke, Recurrent fainting

7. Has your child had a recent nose, throat, chest cold or flu?_____Yes No

If yes for how long? _____Has it resolved?_____(days/weeks)

Are there persistent symptoms? (i.e.: cough, runny nose, fever, home from school, school nurse visits?_____

8. Does your child have/had any of the following lung diseases or complications?_____Yes No

Circle that apply: Chronic cough, bronchitis, pneumonia, chronic sinus disease, seasonal allergies

9. Has your child ever had Asthma?_____Yes No

When was the last attack? _____(Weeks/Months/Years)

How severe and how often do the attacks occur?_____

Does your child need daily medication for his/her asthma? Or as needed?_____ Everyday As Needed

Have steroids been given to your child for their asthma?_____Yes No

10. Does your child have Tonsil or Adenoid problems?_____Yes No
11. Has your child been diagnosed with Sleep Apnea or snore excessively loud at night?_____Yes No
12. Does your child have/had any of the following diseases:

    Liver (hepatitis, Jaundice)?_____Yes No
    Kidney(kidney stones, ureter or bladder disorders, renal insufficiency or failure)? Yes No
    Thyroid Disease?_____ Yes No
    Diabetes?_____ Yes No Type?_____
    Stomach Problems (ulcers, stomach acid issues, reflux/GERD, persistent diarrhea, weight loss)? ____Yes No
    Arthritis (swollen or painful joints or lymph nodes)_____Yes No
    Muscle Disorders or weakness (low muscle tone, muscular dystrophy)?_____ Yes No
    Seizures, Fainting Spells, Frequent Headaches, or other neurological problems _____Yes No
    Does your child have any of the following? (Circle that apply): Intellectual disabilities, ADHD, Autism, PDD, Mental Health issues
    Cancer, STD's, HIV, AIDS_____Yes No

13. Does your child bruise easily, or have they ever been diagnosed with a bleeding disorder?_____Yes No
14. Has your child been diagnosed with a blood disorder like sickle cell anemia or trait?_____Yes No
15. Has any blood relative of your child, ever had a bad or unusual reaction to anesthesia?_____Yes No
16. If there is anything not listed above that your child has or had medically? If yes, please explain:_____

_____.

I understand that withholding any information about my child's health could seriously jeopardize his/her safety. I have carefully reviewed the above medical health history carefully and answered all the questions truthfully and best to my knowledge. I also hereby give permission to the staff of Ambulatory Dental Anesthesia to discuss my child's medical health with other professionals involved with his/her care.

Sign Here:_____Print Name:_____Date:_____/____/_____