Electronic Form - Please Use Computer to Fill out Form & Email to ADAofNY@gmail.com

Ambulatory Dental Anesthesia of New York PC

Medical History Questionnaire

Parents, please take some time to fill this form and should you require more space, please use the back.

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**?____

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

What was 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:_____/____/_____

Use This Page to Include Additional Information: