

PEDIATRIC HEALTH HISTORY FORM (CONFIDENTIAL)

1. Last Name: _____ First Name: _____ Date: _____

Address: _____ Apt/Unit #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Gender: _____ Height: _____ Weight in lbs: _____
 Male Female

Emergency Contact: _____ Phone Number: _____

If you are completing this form for another person, what is your relationship to that person?

2. Please answer the following questions.

Please describe your child's current physical health: <input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Poor	My child's last complete physical exam was on _____	Is your child now under the care of a physician? <input type="radio"/> Yes <input type="radio"/> No
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3. If your child is currently under the care of a physician:

What is the condition being treated?

Physician's Name: _____ Phone Number: _____

4. Has your child had any illness or operation that required hospitalization?

Yes
 No

5. Please list was the illnesses or operations?

6. Please list all medications your child is currently taking

7. Please list all allergies to medication, latex, or food:

8. Please describe your child's physical activity

9. Date of last cold, cough, or fever

Does your child snore at night?

Yes No

Has your child or a close relative ever had a bad reaction to any anesthetic drug?

Yes No

Have you ever had complications during a previous anesthetic?

Yes No

10. Does your child have or had any of the following diseases or problems

	Yes	No		Yes	No
Heart Defects/Heart Murmur			Hepatitis/ Liver Problems		
Bleeding Problems			Seizures/Epilepsy /Fainting Spells		
Cerebral Palsy			Cancer		
Tuberculosis			Asthma/Bronchitis/Lung Problems		
Kidney Problems			Diabetes		
Handicaps/Disabilities			Developmentally Delayed		
Hearing Impairments					

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform the anesthesiologist of any changes in my medical status at the earliest possible time.

Signature of Parent/Guardian/Patient

Signature

Date

Reviewed by: Jinsoo Kim, DDS/William Baltazar, DDS/Hunter Stuart, DDS

Signature

Date