LONE STAR DENTAL ANESTHESIA
4112 East Renner Road
Richardson, TX 75082
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PEDIATRIC HEALTH HISTORY FORM (CONFIDENTIAL)

1. Please enter your child's information:

Patient Last Name: _____

Patient First Name: _____

Patient Date of Birth: _____

Gender:
- Male
- Female

Address: _____

Apt/Unit #: _____

Parent/Guardian Name: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Patient's Height: _____

Patient's weight in lbs: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

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

_____

Who is your dentist?

_____

2. Please answer the following questions:

Please describe your child's current physical health:
- Excellent
- Good
- Poor

Your child's last complete physical exam was on _____

Pediatrician's Name: _____

Phone Number: _____

Is your child currently under the care of any other physicians?
- Yes
- No

If so, what medical condition(s) are currently being treated by this physician?

_____

Please list all other physicians currently being seen:

Physician's Name: _____

Phone Number: _____

Physician's Name: _____

Phone Number: _____

3. Has your child had any illness or operation that required hospitalization or had same-day surgery?

○ Yes ○ No

4. Please list the illnesses or operations:

_____

_____

_____

_____

5. Please list all medications your child is currently taking: If no medications, please write 'NONE':

_____

_____

_____

_____

6. Please list all allergies to medication, latex, or food: If no allergies, please write 'NONE':

_____

_____

_____

_____

7. Please describe your child's physical activity:

_____

_____

_____

_____

8. Date of last cold, cough, flu or fever

_____

Has your child ever use breathing treatment/inhaler previously?

○ Yes ○ No

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

Has your child or a close relative ever had complications during a previous anesthetic?

○ Yes ○ No

If you answered yes to any of the above, please explain:

_____

9. Please indicate if your child was born full term or pre-mature:

☐ Full Term ☐ Pre-Mature

Child was born at how many months or weeks?

_____

10. If born pre-mature, please describe child's hospital course including birth weight in detail:

Did they require oxygenation support?
○ Yes ○ No

11. 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/Anemia			Seizures/Epilepsy/Fainting Spells		
Cerebral Palsy			Cancer		
Tuberculosis			Asthma/Bronchitis/Lung Problems		
Kidney Problems			Diabetes		
Handicaps/Disabilities			Developmentally Delayed		
Hearing Impairments			Autism		

12. Does your child have any other medical diseases or concerns not listed above?

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.

13. Who is your provider?

○ Jinsoo Kim ○ William Baltazar ○ Hasan Zia
○ Allison Lee

Signature of Parent/Guardian/Patient

Signature Date

Reviewed by: Jinsoo Kim, DDS/William Baltazar, DDS/Hasan Zia, DDS/Allison Lee, DDS

Signature Date