Pediatric/Teen Health History

PATIENT INFORMATION (CONFIDENTIAL)

Date:

Name: Birth Date: Age:

Address: City: State: Zip:

Name of Person Responsible for the Account: .

Relationship to Patient: Email (optional): .

Home Phone: Cell Phone .

MEDICAL HISTORY

1. Weight:
2. Is your child/teen currently under the care of a physician for a specific condition? Yes No
3. Date of last physical exam/checkup?
4. Has your child/teen had a recent cold, cough or fever?
5. Describe your child/teen's activity level (Circle one): low or high energy
6. Has there been any change in your child/teen's health in the last year? Yes No
7. Has your child/teen had any hospitalizations or surgeries? Yes No
   a. If yes, when and why
8. Does your child/teen have any cardiac conditions? Yes No
   a. If yes, circle- arrhythmia's, congenital heart disease, murmurs
      Other:
9. Does your child/teen have pulmonary disease or symptoms? Yes No
   a. If yes, circle- asthma, bronchitis, cystic fibrosis, frequent colds/flu, persistent cough, wheezing
      Other:
10. **Females**: Is there any possibility of pregnancy? Yes No
11. Has your child/teen ever been diagnosed with sleep apnea? Yes No
12. Has your child/teen been diagnosed or ever had any of the following medical problems?
    a. Arthritis
    b. Autism
    c. Bleeding Problems / Bruise easily
    d. Blood disorder
    e. Cancer
    f. Cerebral palsy
    g. Diabetes
    h. Down's syndrome
    i. Fainting episodes
    j. Hepatitis / Liver problems
    k. Kidney Problems
    l. Muscle weakness
    m. Seizures / Epilepsy
    n. Other:

12. Please list all medications that your child/teen is currently taking:

13. Does your child/teen have allergies to medication or food? Yes No
    a. If yes, list all allergies
14. Have you or a close relative ever had a bad reaction to any anesthetic drug? Yes No
13. Has anyone in your family been diagnosed with malignant hyperthermia? Yes No
15. Has your child/teen had a previous general anesthetic? Yes No
    a. If yes, were there any complications? Yes No

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 Dr. Barry Krall of any changes in my child/teen's medical status at the earliest possible time.

Signature of Parent/Guardian Date .

Reviewed by: Barry Krall, DDS Date .