Jeffrey P. Fisher, DDS

"Anesthesia for Little People"

Pediatric Medical/Health History

(For patients under 12 years of age)

Patient's Name: _____ Date of Birth: _____ Gender: ____ Age: _____ Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Parent/Guardian:_____ Home Tel: (____)_____ Other: (____)_____

List *all medications* currently being taken by your child (including vitamins, herbs, and laxatives): _____

_____

Does your child have *allergies* to any medications or foods? Yes No If yes, which ones? _____

Has your child had COVID-19 within the past 30 days or been vaccinated for COVID-19 within the past 30 days? Yes No

1. Is your child in good health?_____ Yes No
2. Is your child currently under the care of a physician? _____ Yes No
3. Has your child had any serious illness, operation, or been hospitalized in the last 5 years? _____ Yes No
4. Does your child have or has he/she had in the past any of the following heart diseases or complications?
   - Congenital heart defects or murmurs? _____ Yes No
   - Damaged heart valves, malfunctioning heart valves, or artificial heart valves? _____ Yes No
   - Arrhythmias or irregular heart beats? _____ Yes No
   - Ventricular septal defect or atrial septal defect? _____ Yes No
5. Does your child have or has he/she had in the past any of the following cardiovascular complications?
   - Chest pain upon exertion? _____ Yes No
   - Shortness of breath after mild exercise or when lying down? _____ Yes No
   - Swelling in the ankles? _____ Yes No
   - High blood pressure? _____ Yes No
   - Stoke or transient ischemic attack?_____ Yes No
   - Heart transplant?_____ Yes No
6. Does your child have or has he/she had in the past any of the following lung diseases or complications?
   - Asthma or reactive airway disease? _____ Yes No
   - Bronchitis, pneumonia, emphysema, tuberculosis, chronic cough?_____ Yes No
   - Chronic sinus problems or seasonal allergies?_____ Yes No
   - Current cold or flu symptoms?_____ Yes No
7. Does your child have or has he/she had in the past any of the following diseases or complications?
   - Liver disease (hepatitis or jaundice)?_____ Yes No
   - Kidney disease? _____ Yes No
   - Thyroid disease? _____ Yes No
   - Diabetes? _____ Yes No
   - Stomach problems (ulcers, excess stomach acid with heart burn, persistent diarrhea and or weight loss)? ____ Yes No
   - Arthritis, swollen and painful joints and lymph nodes?_____ Yes No
   - Seizures (epilepsy), fainting spells, or other neurological problems? _____ Yes No
   - Mental retardation, autism, or any other problems with mental health? _____ Yes No
   - Cancer? _____ Yes No
   - Sexually transmitted diseases, HIV, AIDS? _____ Yes No
8. Does your child bruise easily or has he/she ever been diagnosed with bleeding disorder? _____ Yes No
9. Does your child have any blood disorders such as anemia or sickle cell anemia? _____ Yes No
10. Has your child spent time in the neonatal intensive care unit because he/she was born prematurely? _____ Yes No
    - Was your child intubated for a prolonged period of time? _____ Yes No
    - Did your child go home with oxygen? _____ Yes No
11. Has any blood relative of the patient ever had a bad reaction to anesthesia? _____ Yes No
12. Does your child have any disease, condition, or complication not mentioned above? _____ Yes No
    If yes, please explain:_____

I understand that withholding any information about my child's health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical/health history carefully and have answered all questions truthfully and to the best of my knowledge.

Parent/Guardian Signature: _____ ***Printed Name:*** _____ ***Date:*** _____