SOBA
Southern Office-Based Anesthesia

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PEDIATRIC MEDICAL HISTORY FORM

Patient's Name: ______________________________ Date of Birth: ____/____/____ Age: _____ Weight: ______lb

Address: ______________________________ City: ______________________ State: _____ Zip: ___________

Treating Dentist: ______________________________ Gender: ________

Date of Surgery: ______________________________ Home: (___) ________________ Cell: (___) ________________

List all **medications** and dosages currently being taken (**include vitamins, herbs, over-the-counter pills**):

____

Do you have **allergies to any medications or foods**? If yes, list and state what happened? ______________________________

1. Is your child in good health? ______________________________ Yes No
2. Was your child born **prematurely**? (if so, how many weeks) ______ weeks. Complications? ______________________ Yes No
   Did your child have a breathing tube? If yes, for a prolonged period? ______________________________ Yes No
3. Is your child currently or regularly under the care of a physician? Name ______________________________ Yes No
   Phone ______________________________
   A. Do he/she see a specialist? If yes, please list with phone #: ______________________________ Yes No
4. **Has your child ever had anesthesia for any procedures?** ______________________________ Yes No
   Please list ______________________________
5. Has your child had any **serious illnesses**, accidents, **surgeries**, or been **hospitalized** in the past? _______________ Yes No
   Please list: ______________________________
6. Does your child have or has he/she had in the past any of the following heart diseases or complications? _____________ Yes No
   Circle all that apply: Heart Attack, Murmurs, Malfunctioning heart valves, Pacemaker/Defibrillator,
   Arrhythmias or irregular heartbeat, Cardiac arrest?
7. Does your child have or has he/she had in the past any of the following cardiovascular (heart) complications? _________ Yes No
   Circle all that apply: Chest pain or cyanosis upon exertion, Shortness of breath on exertion
   High blood pressure, Stroke, Recurrent Fainting, Palpitations
8. Has your child had a recent runny nose, cough, cold, fever, or flu? ______________________________ Yes No
   How long has it been fully resolved? ________ (days / weeks)
9. Does your child have or has he/she had in the past any of the following lung diseases or complications? _____________ Yes No
   Circle all that apply: Asthma, Bronchitis, pneumonia, Chronic cough, Chronic sinus disease, Seasonal allergies
10. If asthma, when was the last attack? _______ (weeks / months / years)
    How severe and how often do the attacks occur? ______________________________
    Does your child need daily asthma medication or do you just use medication as needed? ____________ Every day As needed
    Have steroid medications ever been used? If so, how often? ______________________________ Last use? _________
11. Does your child have Tonsil or Adenoid problems? ______________________________ Yes No
12. Have your child been diagnosed with Sleep apnea or is there loud snoring every night when sleeping? ____________ Yes No
13. Does your child have or has he/she had in the past any of the following diseases or complications? _______________ Yes No
    Liver (Hepatitis, jaundice)? ______________________________ Yes No
    Kidney (Kidney stones, Ureter or Bladder disorders, Renal insufficiency or failure)? ___________________ Yes No
    Thyroid Disease or Diabetes? ______________________________ Yes No
    Stomach Problems (ulcers, excess stomach acid, or reflux, persistent diarrhea, weight loss)? _______________ Yes No
    Muscle disorders or weakness (Low muscle tone, muscular dystrophy)? ______________________________ Yes No
    Seizures, Fainting Spells, Frequent Headaches, or other neurological problems? ______________________ Yes No
    Intellectually challenged, Depression, ADHD, Autism, PDD, or any other problems with mental health? _____ Yes No
    Cancer, Sexually transmitted diseases, HIV, AIDS? ______________________________ Yes No
14. Does your child bruise easily or has he/she ever been diagnosed with a bleeding disorder? ___________________ Yes No
15. Does your child have any blood disorders such as Anemia or Sickle Cell Anemia? ______________________ Yes No
16. **Has any blood relative of the patient ever had a bad or unusual reaction to anesthesia?** __________________ Yes No
17. Does your child have any disease, disorder, 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. I hereby give permission to Southern Office-Based Anesthesia to discuss my child's medical health with other health professionals involved with my child's care.

Patient Signature: ______________________________ **Printed Name:** ______________________________ **Date:** ___/___/___