

PRE-OPERATIVE MEDICAL HISTORY

To be completed for all patients scheduled for anesthesia.

Patient Name _____ Date of Surgery _____
Age _____ Sex _____

Procedure _____ Dentist: Dr. Alicia Wong

DOES YOUR CHILD:

- | | | |
|--|-----|----|
| 1. Take prescription drugs (please list) | YES | NO |
| 2. Take non-prescription drugs (please list) | YES | NO |
| 3. Have a cold | YES | NO |
| 4. Have any loose teeth | YES | NO |
| 5. Have any drug allergies | YES | NO |

DOES YOUR CHILD HAVE OR EVER HAD:

- | | | |
|--|-----|----|
| 1. Anesthesia | YES | NO |
| 2. Difficulty with anesthesia | YES | NO |
| 3. Difficulty with prior intubations | YES | NO |
| 4. A relative who had difficulty with anesthesia | YES | NO |
| 5. Does anyone in your family have or had: | | |
| Muscular dystrophy | YES | NO |
| Malignant hypothermia | YES | NO |
| Pseudocholinesterase deficiency | YES | NO |
| Sickle cell disease | YES | NO |
| Asthma | YES | NO |
| Bronchitis | YES | NO |
| Emphysema or other lung problems | YES | NO |
| Abnormal chest x-ray | YES | NO |
| Hypertension | YES | NO |
| Chest pain | YES | NO |
| Angina pectoris | YES | NO |
| Irregular heart beat | YES | NO |
| Rheumatic fever | YES | NO |
| Heart murmur | YES | NO |
| Other heart problems or abnormal EKG | YES | NO |

(Continue on backside)

Bleeding or clotting problems	YES	NO
Convulsions or seizures (epilepsy)	YES	NO
Stroke	YES	NO
Muscle weakness, Dizziness or other neurological problems	YES	NO
Hepatitis or jaundice	YES	NO
Diabetes	YES	NO
Kidney problems or blood in urine	YES	NO
Cortisone pills or injections	YES	NO
Frequent heartburn, stomach ulcers or hiatal hernia	YES	NO
Blood transfusion and/or blood transfusion reaction	YES	NO

PLEASE EXPLAIN ANY "YES" ANSWERS: _____

Signed by parent or guardian: _____

Patient's Name: _____

Phone: _____ **Date:** _____