Little Dreamers Dentistry
for dentistry asleep...

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Patient Name: _____ **Date:** _____

	Yes	No	Unsure
1. Does your child have any health problems or concerns? If yes, Please Explain:			
2. Has your child had ANY change in their health in the last 12 months? 3. When was your child's last physical? (month) _____, (year) _____ 4. Is your child under the care of any specialist (eg. Cardiologist, Pediatrician, Respirologist, Hematologist OR another?) Why?			
5. Has your child ever had general anaesthesia or surgery? When, where, and why? _____ 6. Did they have any complications from the anaesthesia? If yes, please explain:			
7. Has anyone in your family had problems with anaesthesia? If yes, Please explain: Did they have any tests done?			
8. Does your child have an allergy to any medications? What drugs? What happened (circle): Rash Breathing problems Wheezing Swelling What was done to treat it?			
9. Do they have any other allergies (eg. Foods or latex?)			
10. Does your child take any medications including puffers/inhalers? Please list:			
11. Does your child take any non-prescription remedies (including herbal) Please list:			
12. Has your child taken a cortisone (steroid) drug by mouth in the past 12 months? If yes, when? what was the dose?			
13. Does your child have any bleeding issues? 14. Do any of your relatives have bleeding disorders?			
15. Does your child have any difficulty breathing through their nose?			
16. Does your child have nose bleeds? If so, how many per month			
17. Does your child snore when sleeping? 18. Does your child have pauses in breathing?			
19. Does your child have problems running around and playing freely, have they ever fainted or had blue spells where their lips and fingers turned blue?			
20. Does your child ever have episodes of blurred vision, black spots, inability to speak, or paralysis in one side of your body, legs, or face?			
21. Has your child ever had surgery or chemotherapy for a tumor or cancer?			
22. Does your child smoke? If so, how many packs/day			
23. Does your child drink alcoholic beverages? How many/week			

Continued	Yes	No	Unsure
24. Do they have a history of alcoholism or drug dependence?			
25. Are you aware if your child has taken any recreational drugs in the past year such as: marijuana, cocaine, MDMA, ketamine, amphetamines, crystal meth, crack, PCPs, codeine? (please circle)			
26. Does your child have any disease, health condition/problem not listed?			
27. What is your child's current: **Height: _____ cm Weight: _____ kg**			

Does your child have, or have you had any of the following?

	Yes	No	Unsure		Yes	No	Unsure
Heart Murmur				Fainting spells, dizziness			
Heart Attack				Diabetes			
Chest pain or angina				Thyroid problems			
Shortness of breath lying down				Adrenal gland problems			
Swollen ankles				Hepatitis			
Heart pacemaker/defibrillator				Liver Disease/Jaundice			
Irregular heart rhythm				Anemia (including sickle cell)			
High blood pressure				Blood disorder/blood transfusions			
Congenital heart disease				Bleeding (coagulation) disorder			
Damaged/abnormal heart valves				Stomach ulcers/ Acid Reflux			
Rheumatic Fever				Bone, joint, or muscle problems			
Kidney disease				Artificial joints			
HIV, AIDS				Arthritis: where _____			
Malignant Hyperthermia				Depression/anxiety			
Pseudocholinesterase Deficiency				Developmental Delay			
Cancer/Chemotherapy				Vision problems, glaucoma			
Sleep Apnea				Cerebral Palsy			
Asthma				Autism			
Bronchitis/Emphysema				Down Syndrome			
Cystic Fibrosis/ Tuberculosis				**WOMEN:**			
Epilepsy				Possibly pregnant?			
Stroke				Nursing?			

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Little Dreamers Dentistry staff will rely on this information for treating my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold members/staff of Little Dreamers Dentistry responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form on behalf of my child.

Name of Parent/ Legal Guardian: _____

Signature of Parent/Legal Guardian: _____Date: _____