Dental Surgical
Center of Medina, Inc
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Patient Identification

PRE- ANESTHETIC HISTORY SHEET

Name ____
Date ____________________________________ Age _____________________ Sex M F
Surgeon _________________________________ Operation ____

Please Circle the correct answer or fill in the blank.

1. List dates/ reasons for previous hospitalization(s) including surgery for your child.
   Date/ reason____
   ____
2. Has your child ever had a general anesthetic?- No Yes
   Were there any serious problems related to the anesthetic(s)?- No Yes
3. Has any family member had a serious problem with anesthesia?- No Yes
4. Does your child take any medicines now? If yes, please list.- No Yes
   ____
5. Does your child have any allergies? If yes, please list. - No Yes
   ____
6. Please check the box if your child has or has had any of the following:

A.) Heart problems - - - - - - - - - - - - - - No Yes
- Heart defect
- Heart murmur
- Prior heart surgery
- Other ________________________________

B.) Breathing problems - - - - - - - - - - - - No Yes
- Asthma
- Croup/ Bronchitis/ Pneumonia
- Cystic fibrosis
- Other ________________________________

C.) Nervous system problems - - - - - - - - No Yes
- Convulsions, seizures, or fits
  ____
- Myelomeningocele
- Hydrocephalus/ VP or VA shunt
- Cerebral Palsy
- Head or spinal injury
- Other ________________________________

D.) Digestive problems - - - - - - - - - - - - - - No Yes
- Hepatitis
- Reflux/ frequent nausea/ vomiting
- Other ________________________________

E.) Loose teeth - No Yes

F.) Glandular problems - - - - - - - - - - - - - - - - - - - No Yes
- Diabetes
- Thyroid
- Other ____

G.) Kidney problems - No Yes

H.) Blood problems - No Yes

I.) Birth problems - No Yes
- Prematurity
- Apnea/ Bradycardia
- Ventilator
- Other

J.) Other health problems or syndromes - - - - - - No Yes
- Down Syndrome
- Chemotherapy
- Muscle disease
- Other ____

K.) Menstruation started - - - - - - - - - - - - - - - - - - No Yes

The following questions should be answered when your child is admitted:

1. Has he/ she had a cold, cough, or sore throat in the past week? - No Yes
2. Does he/ she have the complaint now? - No Yes
3. Time of last food and/or liquid ____
4. Are there any cultural, religious or ethnic concerns that could affect the care of your child? - - - - - - - - - - - - - - - No Yes

   If yes, describe ____

I understand and accept the risks of anesthesia. All my questions have been satisfactorily answered.

Guardian's Signature ____ Relationship to Patient ________________________

Initial _______ I do want, if indicated, regional anesthetic techniques employed for anesthetic maintenance and/ or post -operative pain relief for my child.