

PATIENT INFORMATION:

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Sex: _____ Height: _____ Weight: _____

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

Home Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY:

Name of Person/Relationship: _____ Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

MEDICAL HISTORY:

Have you ever had any of the following medical problems?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergy to Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Palsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Medications (Please list below) | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma/Lung Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Parkinson's Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Cholesterol | <input type="checkbox"/> Y <input type="checkbox"/> N Alzheimer's Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmurs/Defects | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Mastocytosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Other Surgery _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Tracheal Malacia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Seizure Disorder (Epilepsy) | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autism | <input type="checkbox"/> Y <input type="checkbox"/> N Muscular Dystrophy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Anemia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Down Syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N Malignant Hyperthermia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Other Syndromes _____ | (Patient or Familial History) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Possibly PREGNANT (Women >10 years old) | |

Please discuss any medical problems that you have/had: _____

Are you currently under the care of a physician? Yes No Date of Last Visit: _____

Physician Name: _____ Phone Number: _____

Are you followed by a SPECIALIST? Yes No Please indicate ALL that apply: Cardiologist Endocrinologist

Geneticist Hematologist Neurologist Oncologist Pulmonologist Other _____

Please list ALL current medications: _____

Please list ALL allergies (medicine, food, latex, etc.): _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the **strictest** of confidence and it is my responsibility to inform the doctors of Arizona Dental Anesthesia of any changes in the medical status of this patient at the earliest possible time.

Signature of Parent or Legal Guardian: _____ Date: _____

Reviewed by: _____ Date: _____