Dr. Andrea Fonner & Dr. Simon Prior
Anesthesiology for Dentistry

Today's Date: _____ Name of Dentist/Dental Clinic: _____

PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ Birth Date: _____

Nickname: _____

Age: _____ Gender: _____ Height: _____ Weight: _____

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

PARENT/GUARDIAN INFORMATION

Name: _____ Birth Date: _____

Relationship to Patient: _____

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Email address: _____

MEDICAL HISTORY

Has your child ever had any of the following? (Circle Y for Yes, N for No)

Y	N	Allergies to any drugs	Y	N	Diabetes/Thyroid problems
Y	N	Take any medications	Y	N	Ulcers/Acid reflux (GERD)
Y	N	Any hospital stays	Y	N	Hepatitis / Liver problems
Y	N	Any operations	Y	N	Seizures / Epilepsy
Y	N	Heart defect	Y	N	Kidney problems
Y	N	Heart murmur	Y	N	Bleeding problems
Y	N	Chest pain	Y	N	Developmentally delayed
Y	N	Heart arrhythmias	Y	N	Physical disabilities
Y	N	Shortness of breath	Y	N	Cerebral palsy
Y	N	Asthma / Reactive airway	Y	N	Autism
Y	N	Pneumonia	Y	N	Cancer
Y	N	Snoring	Y	N	Hearing impairments
Y	N	Sleep apnea	Y	N	Around second-hand smoke
Y	N	Frequent nosebleeds	Y	N	Sedation/General Anesthesia

Please discuss any medical problems: _____

Pediatrician: _____ Phone Number: _____Date of Last Visit: _____

Please list all medications the child is currently taking: _____

_____

Please list all allergies, including medications: _____

The information on this questionnaire is accurate to the best of my knowledge.

Signature of Patient/Legal Guardian **Date**