Op Med History

Pediatric DENTAL SPECIALISTS, P.A.

CREATING SOMETHING TO SMILE ABOUT!

Patient Name: _____ **Age:**_____ **Date of Birth:**_____ **Gender: M F**

1) **Does your child have or have they ever been diagnosed with:**

Asthma/Asthma like symptoms	**YES/NO**	Heart Murmur	**YES/NO**
Nut/Dye/Latex/Other Allergy	**YES/NO**	Sleep Apnea	**YES/NO**
Hemophilia/Bleeding Issues	**YES/NO**	Glaucoma	**YES/NO**

2) **Have there been any changes in your child's medical history:**

Ear Infections (past 4 weeks)	**YES/NO**	Contagious Disease/Virus (past 4 weeks)	**YES/NO**
Asthma Attack (past 4 weeks)	**YES/NO**	Upper Respiratory Infection (past 6 weeks)	**YES/NO**
Strep Throat (past 2 weeks)	**YES/NO**	Fever/Recent Illness/Congestion (past 2 weeks)	**YES/NO**
Sinus Infection (past 2 weeks)	**YES/NO**	Ongoing Staph/MRSA Infection (past 4 weeks)	**YES/NO**
Pregnancy	**YES/NO**	Pink Eye, Lice, Poison Ivy/Poison Oak (past 2 weeks)	**YES/NO**

If yes to any, please describe:_____

3) **Has your child undergone any medical procedures (Ex: tonsillectomy, broken bone, pin/screw placement, etc.)? YES/NO**
Any complications: **YES/NO** If yes to either, please describe/date:_____

4) **Does your child require antibiotics prior to dental treatment (heart murmur, shunt, prosthetic device, pins/screws, etc.)? YES/NO**
If yes to any, please describe:_____

5) **Has your child or family member ever had any issues with anesthetics (topical or local) or anesthesia (mild, moderate, deep [including IV], or general)? YES/NO.** If yes to any, please describe:_____

6) **Has your child been given any prescription, over-the-counter, dietary, or herbal medicines within the last 48 hours? YES/NO**
If yes, please describe:_____

7) **Last time your child had anything to eat or drink?** Date/Time _____ Description _____

Person Accompanying Child: Are you: ☐Parent ☐ Step-Parent ☐Grandparent ☐Other (Please specify) _____

Name (Please Print):_____**Phone:**_____

Do you have any concerns for today's visit? ☐ No ☐Yes **(please list)** _____

_____

Has your child been seen by another dentist or dental specialists since their last visit here? ☐ No ☐ Yes If yes, please describe: _____
_____ **☐ No ☐ Yes Were x-rays taken?**

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? ☐ No ☐ Yes If yes, please describe:
_____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest confidence. I also understand that is it my responsibility to inform this office of any changes in my child's medical status, address, phone number, email address or any other personal information. I give Pediatric Dental Specialists, P.A. permission to perform cleaning, x-rays, exam and fluoride treatment, sealants (with prior authorization), or emergency treatment for my child.

_____ _____ _____
Signed (Patient or legal guardian if a minor) Print Name Date

For Office Use Only

Time_____ Age_____ Height_____ Weight_____ BP_____ Pulse_____ O2 Sat_____ RR_____ ASA_____ **TXP Y N**

Med. Hx. Reviewed by: _____