SoCal Sleep Dentistry
Pediatric Health History Questionnaire

Patient Name: _____ DOB: _____ Age: _____

Sex (Circle): Male / Female Height: _____ Weight: _____
Guardian Name: _____ Relationship: _____
Phone Number: _____ Alternate #:_____
Physician Name: _____ Date of Last Physical: _____

Has your child had any of the following? Please check:

☐Yes ☐No Allergies? (Food, medications, latex, seasonal) What happens?
_____

☐Yes ☐No Medications? (Prescriptions, inhalers, over-the-counter, vitamins)
_____

☐Yes ☐No Previous surgery or anesthesia?
_____

☐Yes ☐No Previous ER visit or hospitalization? When and why?
_____

☐Yes ☐No Medical specialists? Cardiology / Neurology / Pulmonology / Gastroenterology
Endocrinology / Hematology / Psychiatry / Other _____

☐Yes ☐No Special medical tests for any reason? _____

☐Yes ☐No Cold, cough, flu in the last 6 weeks? When? _____

☐Yes ☐No Family history of malignant hyperthermia or problems with anesthesia? _____

Immunizations up to date? _____

Premature birth? By how many weeks? Any complications (apnea, bradycardia events)?

Has your child ever experienced any of the following? Please check the box or circle if YES:

☐Asthma, Wheezing, Shortness of Breath
☐Bronchitis, Pneumonia, Chronic Cough
☐Croup, Stridor
☐Sinus Problems
☐Tonsil or Adenoid Problems
☐Sleep Apnea, Sleep Disordered Breathing
☐Innocent Heart Murmur
☐Irregular Heart Beat, Arrhythmia
☐Congenital Heart Defect, Abnormal Heart Valve, Atrial or Ventricular Septal Defect
☐Fainting Spells or Blackouts
☐High Blood Pressure
☐Rheumatic Fever, Scarlet Fever
☐Frequent Nose Bleeds
☐Excessive Bleeding, Clotting Problems
☐Anemia
☐Sickle Cell Disease, Thalassemia
☐Thyroid or Endocrine Problem
☐Acid Reflex, Indigestion, Hiatal Hernia
☐Difficulty Swallowing, Aspiration
☐Stomach or Intestinal Problems
☐Kidney Problems
☐Liver Problems
☐Diabetes (Type I or Type II)
☐Muscle Disorders (e.g. Muscular Dystrophy)
☐Head or Neck Injury
☐Seizures
☐Developmental Delay (Speech, Motor)
☐ADD/ADHD
☐Autism Spectrum
☐Anxiety / Depression / Mood Disorders
☐Down Syndrome or Other Syndrome
☐Cerebral Palsy
☐Cancer, Chemotherapy, Radiation Therapy
☐Infections (TB, HIV, Hepatitis)
☐Autoimmune Disorder
☐Other _____

Name: _____ Signature: _____ Date: _____
(Parent or Guardian)