ANESTHESIA
ASSOCIATES OF CENTRAL PENNSYLVANIA

Kevin Dincher. DMD, Dentist Anesthesiologist
1019 Ghaner Rd. State College PA 16870
Phone: (814) 862-9603
FAX (866) 422-9701

Parents/care givers, please take time to carefully fill out this questionnaire.

Patient's Name: _____ Date of Birth: ____/____/____ Age: _____ Weight: _____lb

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

Parent's Names: _____ Home: (___) _____ Cell: (___) _____

Date of Scheduled Treatment: ___/____/____ Dentist/Surgeon's Name: _____ Best Time to Call: _____

List all **medications** currently being taken by your child (**include vitamins, herbs, over-the-counter pills**): _____

_____

Does your child have **allergies to any medications or foods**? If yes, list and state what happened? _____

1. Is your child in good health? _____ Yes No
2. Was your child born prematurely? (if so, how many weeks) _____weeks. Complications? _____
   Did your child have a breathing tube? If yes, for a prolonged period? _____ Yes No
3. Is your child currently or regularly under the care of a physician _____ Yes No
   A. Do they see a specialist? If so please list with phone #: _____
4. Has your child had any serious illnesses, accidents, operations, or been hospitalized in the last 5 years? _____ Yes No
   Please list: _____
5. Does your child have or has he/she had in the past any of the following heart diseases or complications? _____ Yes No
   Circle all that apply: Congenital heart defects, Murmurs, Malfunctioning heart valves, Pacemaker, Arrhythmias or irregular heart beats, Ventricular or Atrial Septal defects?
6. Does your child have or has he/she had in the past any of the following cardiovascular (heart) complications? _____ Yes No
   Circle all that apply: Chest pain or cyanosis upon exertion, Shortness of breath on exertion High blood pressure, Stroke, Recurrent Fainting
7. Has your child had a recent nose, throat, chest cold or flu? _____ Yes No
   How long has it been fully resolved? _____ (days / weeks)
   Are there continued symptoms (example, cough, fever, home from school, nasal discharge)? _____ Yes No
8. Does your child have or has he/she had in the past any of the following lung diseases or complications? _____ Yes No
   Circle all that apply: Bronchitis, pneumonia, Chronic cough, Chronic sinus disease, Seasonal allergies
9. Has your child ever had Asthma? _____ Yes No
   When was the last attack? _____ (weeks / months / years)
   How severe and how often do the attacks occur? _____
   Does your child need daily asthma medication or do you just use medication as needed? _____ Every day As needed
   Have steroid medications ever been used? If so, how often? _____ Last use? _____
10. Does your child have Tonsil or Adenoid problems? _____ Yes No
11. Has your child been diagnosed with Sleep apnea or is there loud snoring every night when sleeping? _____ Yes No
12. Does your child have or has he/she had in the past any of the following diseases or complications? _____ Yes No
    Liver (Hepatitis, jaundice)? _____ Yes No
    Kidney (Kidney stones, Ureter or Bladder disorders, Renal insufficiency or failure)? _____ Yes No
    Thyroid Disease or Diabetes?_____ Yes No
    Stomach Problems (ulcers, excess stomach acid, or reflux, persistent diarrhea, weight loss)? _____ Yes No
    Arthritis (swollen or painful joints or lymph nodes)? _____ Yes No
    Muscle disorders or weakness (Low muscle tone, muscular dystrophy)? _____ Yes No
    Seizures, Fainting Spells, Frequent Headaches, or other neurological problems? _____ Yes No
    Mental Retardation, Depression, ADHD, Autism, PDD, or any other problems with mental health? _____ Yes No
    Cancer, Sexually transmitted diseases, HIV, AIDS? _____ Yes No
13. Does your child bruise easily or has he/she ever been diagnosed with a bleeding disorder? _____ Yes No
14. Does your child have any blood disorders such as Anemia or Sickle Cell Anemia? _____ Yes No
15. Has any blood relative of the patient ever had a bad or unusual reaction to anesthesia? _____ Yes No
16. Does your child have any disease, disorder, or complication not mentioned above? _____ Yes No
    If yes, please explain: _____

Additional Comments: _____

I understand that withholding any information about my child's health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Dr. Dincher to discuss my child's medical health with other health professionals involved with my child's care..

Parent / Guardian Signature: _____ **Printed Name:** _____ **Date:** ___/___/___