



MEDICAL HISTORY

Patient's Name:	Date of Birth: / /	Height:	Weight:
Street Address:	City:	State:	Zip:
Responsible Party's Name:	Relationship to patient:		
Phone: Cell	Home:	Work:	

Has the patient ever had any of the following?

1. Heart Conditions (congenital defects, shortness of breath, pacemaker, murmur, high blood pressure) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Blood conditions (anemia, easy bruising/bleeding, hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Lung conditions: (emphysema, shortness of breath, TB, asthma, recent cold or flu, RSV) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Digestive tract or abdominal conditions (stomach ulcers, reflux, nausea, difficulty swallowing): If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Infectious conditions: (AIDS, hepatitis, herpes/cold sores) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Endocrine conditions (thyroid, parathyroid disease or calcium deficiency, diabetes) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Autoimmune Conditions: (rheumatoid arthritis, lupus) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Neurological conditions (epilepsy, seizures, autism, ADHD, stroke) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Muscular problems (weakness, paralysis, muscular dystrophy) If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Congenital disabilities or syndromes, like Trisomy 21 (Down Syndrome): If yes, please explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Kidney Problems: (kidney failure)	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Has the patient or any blood relatives ever had problems with general anesthesia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please list all serious medical conditions or hospitalizations and dates: _____ _____	
Please list all surgical operations and dates: _____ _____	
Please list all allergies (food, medicine, latex, etc): _____ _____	

I understand that withholding or misrepresenting any information about my child's health could seriously jeopardize his/her safety. I have carefully reviewed the above medical health history and answered all questions to the best of my knowledge. I understand it is my responsibility to inform the doctors of Dream Guard Anesthesia of any changes in medical status.

Parent/Guardian Signature

Date