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Pediatric Health History Questionnaire

Patient Name _____ DOB _____ Age _____
Sex ☐ Male ☐ Female ☐ Other Height _____ Weight _____
Guardian Name _____ Relationship_____
Phone Number _____ Alternate # _____
Physician Name_____ Date of Last Physical _____

Has your child had any of the following?

☐ 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 for what?
_____
☐ Yes ☐ No Medical specialists? ☐ Cardiology ☐ Neurology ☐ Pulmonology ☐ Hematology
☐ Endocrinology ☐ Gastroenterology ☐ Psych ☐ ENT ☐ Genetics ☐ Other
☐ Yes ☐ No Special medical tests for any reason? _____
☐ Yes ☐ No Premature birth or complications at birth?
_____
☐ Yes ☐ No Delays in development? (Crawling, walking, talking, other milestones)
☐ Yes ☐ No Cold, cough, flu in the last 6 weeks?
☐ Yes ☐ No Snoring at night?
☐ Yes ☐ No Family history of malignant hyperthermia or problems with anesthesia?
☐ Yes ☐ No Behavioral, emotional, cultural or spiritual concerns we need to be aware of?
☐ Yes ☐ No Immunizations up to date?

☐ Asthma, Wheezing, Shortness of Breath
☐ Bronchitis, Pneumonia, Chronic Cough
☐ Croup, Stridor
☐ Sinus Problems
☐ Tonsil/Adenoid Problems or Sleep Apnea
☐ 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 Reflux, Indigestion, Hiatal Hernia
☐ Difficulty Swallowing, Aspiration
☐ Stomach or Intestinal Problems
☐ Liver Problems
☐ Kidney Problems
☐ Diabetes
☐ Muscle Disorders (e.g. Muscular Dystrophy)
☐ Head or Neck Injury
☐ Seizures
☐ ADD/ADHD
☐ Autism Spectrum
☐ Anxiety/Depression/Mood Disorders
☐ Down Syndrome or Other Syndrome
☐ Cerebral Palsy
☐ Cancer, Chemo, or Radiation Therapy
☐ Infection (TB, HIV, Hepatitis)
☐ Other _____

Name _____ Signature _____ Date _____
(Parent or Guardian)

INFORMED CONSENT FOR ANESTHESIA

Dr. Christina Baek, DDS

I understand that the purpose of an informed consent is to make me aware of the choices and risks involved in having dentistry performed under anesthesia. I am provided with this information so I can make well-informed decisions concerning my treatment. The options for anesthesia include: local anesthesia, conscious sedation, general anesthesia, and no anesthesia. Anesthesia can be safely administered in an office, surgery center, or hospital setting. I have been made aware of the different risks associated with the various modes of anesthesia.

The most frequent side effects of conscious sedation or general anesthesia are drowsiness, nausea, vomiting, and phlebitis. Most patients remain drowsy or sleeping following their surgery for the remainder of the day, and coordination and judgment may be impaired for as long as 24 hours. I have been advised to refrain from operating a vehicle or making any major decisions for this time period. I have also been advised to refrain from alcohol or other sedative drugs for the next 24 hours. If the patient is a child, I have been informed of the necessity for direct (one-on-one) supervision of my child for up to 24 hours following anesthesia.

I have been informed and understand that occasionally there are anesthesia-related complications, including but not limited to: pain, hematoma, numbness, swelling, bleeding, nausea, vomiting, headache, hoarse voice and/or sore throat, sore nose, awareness, delay in recovery, allergic reaction, and fluctuations in breathing pattern, heart rhythm, and/or blood pressure. Furthermore, I understand and accept the extremely remote possibility that rare life-threatening complications may require hospitalization, and/or result in brain damage, stroke, heart attack, or death.

I have honestly informed the anesthesiologist of: the time I last had food or drink, my past and present medical issues, my surgical history, my known allergies, my current and past medications, and my use of other substances such as illicit drugs, vitamins, and natural supplements.

FEMALES: I understand that anesthetics and medications may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Christina Baek of a suspected or confirmed pregnancy, with the understanding that this will necessitate postponement of the anesthesia. Additionally, I understand that I must inform the anesthesiologist if I am a nursing mother.

I hereby authorize and request Dr. Christina Baek, DDS to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic(s) by any route deemed suitable by the anesthesiologist. I understand the anesthesiologist is an independent contractor and consultant, and I understand she will have full charge of the administration and maintenance of anesthesia, and that this is an independent function from the surgical/dental treatment I will receive. The anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and the dentist assumes no liability for the anesthesia.

I have been fully advised and fully understand the risks, benefits, and alternatives to the type of anesthesia that has been chosen, and I accept all possible risks and consequences. I acknowledge the receipt of, and completely understand, both pre-anesthesia and post-anesthesia instructions. It has been explained to me and I understand that there is no warranty and no guarantee of any result or cure.

I have read fully and understand the above information and all of my questions have been answered to my satisfaction. I hereby consent to the administration of anesthesia during my or my child's treatment or surgery, and I have signed this consent prior to the administration of anesthesia.

Patient Name _____ Date _____

Parent/Guardian Name _____ Relationship to Patient _____

Signature _____Witness_____

PRE-ANESTHESIA INSTRUCTIONS FOR PARENT/GUARDIAN

EATING AND DRINKING

- It is extremely important that the patient has an empty stomach prior to anesthesia. Failure to follow fasting instructions could result in aspiration, a life-threatening emergency. Please make sure all adults in the house know these rules.
    - 8 hours before appointment: Stop food and non-water liquids. This means no snacks, no milk, no breastmilk, no broth, no orange juice, no candy/gum, no food whatsoever for eight (8) hours prior to the appointment. Make sure your child has no access to food or drink during the night. If needed, small sips of plain water may be given.
    - 2 hours before appointment: Stop water 2 hours before the appointment.
    - Do not let your child be unattended the morning of the appointment. Please do not take them to school, and do not let them shower or brush their teeth alone to ensure they do not swallow anything.

CHANGE IN HEALTH

- If the patient develops signs of a cold, including a runny nose, cough, or fever, please inform the office, as your appointment may need to be rescheduled for when your child is well.

CLOTHING

- Dress your child in loose comfortable clothing and a short-sleeve T-shirt or tank top.
- No onesies, one-piece jumpers, or footed nylons or stockings. We will be placing monitors on the toes.
- Please bring a warm blanket as patients often get cold during anesthesia.
- Have your child use the restroom (with your supervision) prior to arrival, OR put them in a diaper or pullup if age-appropriate. Please bring a change of clothing in case of an accident.
- Long hair should be tied back, and jewelry should be removed.

COMMUNICATION

- The anesthesiologist will be in contact with you the day or evening before the appointment. She is happy to speak with you in advance of this should you have any questions or concerns, please inform the office if so.

DAY OF SURGERY

_____ I am aware of the 8-hour fasting requirement and will keep a close eye on my child prior to the appointment and for the remainder of the day.

_____ I have fully disclosed all health history and understand this is for the safety of the patient.

_____ I am aware that surgery days are unpredictable and that appointment times are tentative. I will be on call to come in earlier if needed.

_____ I am aware that as parent/guardian I am not allowed in the operatory at time of surgery.

_____ I understand that as parent/guardian I must be present in the dental office or in my vehicle on the dental office premises at all times during the appointment.

_____ I understand the anesthesiologist reserves the right to cancel the scheduled appointment for any reason that may jeopardize the safety of the anesthetic procedure.

I have reviewed and understood the given instructions:

Parent Name:	Relationship:
Signature:	Date:

Christina Baek, DDS Dentist Anesthesiologist (818) 515-9447	Patient: Date & Time:

POST-ANESTHESIA DISCHARGE INSTRUCTIONS

ACTIVITY	The patient may feel tired and sleepy for several hours after the appointment. The patient should not drive, bike, swim, sign important documents, or do other activities requiring coordination for the remainder of the day. If the patient is a child, please ensure a responsible adult is available to care for the child for the rest of the day. Please do not leave the child unattended or allowed to nap alone. Patients should be fully recovered and may go back to school or work the following day.
DIET	Patients should start with drinking clear liquids (water, tea, Gatorade) and then progress to soft foods, such as mashed potatoes, rice, soups, and noodles. It may be best to avoid heavy or greasy meals until the patient has recovered. The dentist may have additional dietary restrictions depending on the dental procedures completed.
NAUSEA / VOMITING	Nausea and vomiting can occur after anesthesia. The patient was given an anti-nausea medication through the IV during the procedure. If the patient becomes nauseous, clear liquids are recommended until the nausea passes. If vomiting persists for longer than 3 hours, please contact the anesthesiologist.
DISCOMFORT / PAIN	It is not uncommon for the patient to experience some discomfort or pain following the dental procedure. The anesthesiologist may have given IV pain medications and the dentist may have given local anesthesia ("Lidocaine") during the procedure but these medications wear off over time. The patient may experience a sore nose or throat, which should resolve in a day or two. If the patient experiences a severe nosebleed or difficulty breathing, please dial 911 immediately and inform your anesthesiologist. Additionally, there may be tenderness or bruising at the IV site, as well as redness where the patient's heart and breathing were monitored. This too will resolve in hours or days.
PAIN / FEVER CONTROL	A low-grade fever, usually under 101° F, may develop after anesthesia. This may be a normal side effect of the medications given, as certain medications may temporarily cause decreased sweating ability. For pain and fever control, over-the-counter medications may be given according to the directions on the box as long as the patient is not allergic: 1. Acetaminophen (Tylenol) may be given immediately, and every 4-6 hours after that as needed. 2. Ibuprofen (Motrin/Advil) may be given after _____ and every 4-6 hours after that as needed. 3. Either acetaminophen or ibuprofen may be given, or BOTH may be given, as needed. Please do not exceed the recommended dosages indicated on the labels. If pain or fever persists despite taking the recommended medications, please contact the office.
MEDICATIONS	The patient should resume taking all prescribed medications at his/her next normally prescribed time.
BLEEDING	If the patient had an extraction, some bleeding is normal. Please follow your dentist's instructions regarding post-operative bleeding control. If bleeding persists longer than you were told or seems excessive, please contact the dental office.

I have reviewed these instructions and have had all my questions answered to my satisfaction. I understand I will receive a copy of these instructions and will provide a phone number where I can be reached the next 24 hours. I will be responsible for the above patient for the remainder of the day and will contact the office or anesthesiologist if I have any concerns.

Name:	Relationship:
Signature:	Phone: