MOBILE DREAMS

Pediatric Medical History Questionnaire

Patient Name:_____Date of Birth:_____Age:_____Weight:_____Height:_____

Address:_____City:_____State:_____ Zip:_____ Contact/Phone:_____

Name of Person Responsible for the Patient: _____Relationship:_____ Driver's License#:_____

Referring Dental office:_____ _____

1. Does your child have now (or had in the past) any health problem?…..……..…Yes No

   If yes, please specify:

2. Has your child seen a doctor for anything other than routine physical exams?……...…… Yes No

   If yes, for what reason?

3. Does your child see (or have they ever seen) any specialist doctors:

Cardiology (heart doctor)	Pulmonology (lung doctor)	Neurology (brain doctor)
Urology (kidney/urinary)	Psychiatrist/Psychologist	Developmental doctor
Ear/Nose/Throat (ENT doctor)	Dermatology (skin)	Endocrinology

   If yes, or OTHER specialist, for what reason?

4. Has your child ever had surgery or anesthesia?…….……... Yes No

   If yes, please list surgery or procedures and age of child at time?

5. Has your child had any problems with anesthesia? ……..……..... Yes No

   If yes, what problems?

6. Has anyone in your child's family had any history of serious anesthesia problems? ……..…… Yes No

   If yes, which family member and what problems?

7. Does your child snore or have sleep apnea? ……..……..... Yes No

8. Has your child had any cough or cold symptoms now or in the last 2 weeks? ……..……..... Yes No

   If yes, please list symptoms, when they started, and if getting better or worse:

9. Has your child had COVID 19? ……..……..... Yes No

   If yes, when?

10. Has your child been exposed to anyone with COVID 19 in the last two weeks? ……..……...Yes No

    If yes, exposed to who and when was exposure?

11. Has your child ever stayed overnight in the hospital?……..…… Yes No

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If yes, for what reason?

12. Is there any activity child is restricted from by a doctor or otherwise?……Yes No

If yes, what?

13. Has your child ever had a bleeding problem?……Yes No

14. Does your child have any allergies to medications or food? ……...Yes No known allergies

If yes please list all allergies:

15. Is your child taking any medications?……...Yes No

If yes, please list all medications your child is presently taking along with doses:

Does your child have now or have they ever had any of the following conditions? Please circle yes or no.

Heart/Blood Vessels
Heart murmur…….Yes No
Irregular/rapid heart beat……Yes No
Congenital heart defect…….. Yes No
Fainting…….. Yes No
Turning blue (cyanosis)……. Yes No
Rheumatic fever/disease…….Yes No
Heart valve damage……Yes No
Pacemaker……. Yes No
High blood pressure……. Yes No
TIA / Stroke……. Yes No
Chest pain/angina……...Yes No
Other heart / vessel disorder. Yes No

Respiratory
Asthma…….. Yes No
Persistent cough……..…….. Yes No
Shortness of breath……..….. Yes No
Tuberculosis…….. Yes No
Other respiratory……..…….. Yes No

Nervous System
Epilepsy/seizures…….. Yes No
Anxiety/depression…….. Yes No
Psychiatric treatment……..Yes No
Counseling……. Yes No
Chronic pain…….. Yes No
Persistent numbness/tingling Yes No
Developmental delay……. Yes No
Cerebral palsy…… Yes No
Autism……Yes No
ADHD……Yes No
Combative / aggressive…..... Yes No
Self-abusive……Yes No
Other……. Yes No

Blood
Bleeding disorder…… Yes No
Bruise easily for no
apparent reason…… Yes No
Other blood disorder…… Yes No
Blood clots or thrombosis… Yes No
Anemia…… Yes No
Sickle cell disease / trait…… Yes No
Hemophilia…… Yes No

Head & Neck
Frequent or severe
nosebleeds……..…….. Yes No
Injury to head,
neck, face, teeth……Yes No
Headaches…….. Yes No
Unexplained visual change… Yes No
Persistent sore throat
or hoarseness……..…….. Yes No
Difficulty swallowing…..….. Yes No
Other head / neck disorder..... Yes No

Endocrine
Diabetes Type I or II……..Yes No
Thyroid problem…… Yes No
Other endocrine condition…..Yes No

Sleep disorders
Snoring……...Yes No
Sleep apnea……Yes No
Day time sleepiness……Yes No
Bedwetting……..….. Yes No
Mouth breathing……Yes No
Restless sleeping……..... Yes No

Urinary Tract
Kidney/renal disease……. Yes No
Other urinary disorder…….. Yes No

Digestive System
Frequent heartburn…...…….. Yes No
Acid reflux/GERD…...…….. Yes No
Frequent nausea/vomiting….. Yes No
Other digestive disorder

Cancer History
Leukemia……..……..Yes No
Tumors/growths……. Yes No
Cancer……..…….. Yes No

If yes, what type: _____

Syndromes:
Down syndrome……. Yes No
Other syndrome:_____

Surgical:
VP shunt or revisions……. Yes No
Vagal nerve stimulator…… Yes No
Blood transfusion…… Yes No

Girls Only
Has menstruation started? …. Yes No

_____ _____
Name of person filling out form Relationship to patient

If you are not the patient, are you
able to give legal consent for the patient? Yes No If "No," who does?

_____
Name of person able to give consent

_____ _____
Signature of parent / guardian / person filling our form Date