SSC2 updated 9.2022

Patient Name:_____

Date of Birth:_____

Weight: _____ HT: _____ Sex: M / F

Medical Record #:_____

Salida Surgery Center
5712 PIRRONE RD, SALIDA, CA 95368

Medical History

Are there any health conditions that necessitate taking medications prior to your child's dental treatment?	□ **Y** □ **N**
Is he / she taking any type of medications, vitamins, or herbal supplements? (If so, please list)	□ **Y** □ **N**

ALLERGIES Is he/ she allergic to the following:

Any kind of medications (please list)	□ **Y** □ **N**	Latex	□ **Y** □ **N**	Other: (please list)
		Metals or acrylics	□ **Y** □ **N**	
		Food	□ **Y** □ **N**	

Has your child ever been hospitalized, had a serious illness / injury, or had any surgeries? (If so, please provide reason & date)	□ **Y** □ **N**

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

AT BIRTH		**MUSCULOSKELETAL**		**ONCOLOGICAL**	
Born Premature	□ **Y** □ **N**	Arthritis	□ **Y** □ **N**	Cancer or malignancy	□ **Y** □ **N**
Congenital abnormalities or inherited disorders	□ **Y** □ **N**	Bone or joint problems	□ **Y** □ **N**	Radiation or chemotherapy	□ **Y** □ **N**
Cleft Lip / palate	□ **Y** □ **N**	Muscle weakness	□ **Y** □ **N**	Other:	□ **Y** □ **N**
CARDIOVASCULAR		**DERMATOLOGICAL**		**INFECTIOUS DISEASE**	
Congenital Heart Defect	□ **Y** □ **N**	Eczema	□ **Y** □ **N**	Measles, mumps, chicken pox	□ **Y** □ **N**
Heart Murmur	□ **Y** □ **N**	Rash or hives	□ **Y** □ **N**	Tuberculosis	□ **Y** □ **N**
Rheumatic Fever	□ **Y** □ **N**	**NEUROLOGICAL**		Mononucleosis	□ **Y** □ **N**
Other:	□ **Y** □ **N**	Fainting or dizziness	□ **Y** □ **N**	Hepatitis	□ **Y** □ **N**
RESPIRATORY		Convulsions or seizures	□ **Y** □ **N**	Other:	□ **Y** □ **N**
Asthma or reactive airway disease	□ **Y** □ **N**	Hydrocephaly	□ **Y** □ **N**	**AUDITORY AND VISUAL**	
Upper respiratory infections	□ **Y** □ **N**	Cerebral Palsy	□ **Y** □ **N**	Chronic ear infections	□ **Y** □ **N**
Snoring or apnea	□ **Y** □ **N**	Mental Disability	□ **Y** □ **N**	Hearing impairments	□ **Y** □ **N**
Other:	□ **Y** □ **N**	Other:	□ **Y** □ **N**	Vision problems	□ **Y** □ **N**
GASTROINTESTINAL		**ENDOCRINE**		**BEHAVIORAL**	
Metabolism abnormalities	□ **Y** □ **N**	Diabetes	□ **Y** □ **N**	Developmental Delay	□ **Y** □ **N**
Gastro esophageal reflux disease	□ **Y** □ **N**	Thyroid Problems	□ **Y** □ **N**	Autism	□ **Y** □ **N**
Ulcers	□ **Y** □ **N**	Growth Delays	□ **Y** □ **N**	ADHD/ Hyperactivity	□ **Y** □ **N**
Eating disorders	□ **Y** □ **N**	Other:	□ **Y** □ **N**	Traumatic stress disorder	□ **Y** □ **N**
Liver Disease	□ **Y** □ **N**	**HEMATOLOGICAL / IMMUNOLOGIC**		Alcohol or chemical dependency	□ **Y** □ **N**
Other:	□ **Y** □ **N**	Excessive bleeding or bruising easily	□ **Y** □ **N**	Psychiatric treatment	□ **Y** □ **N**
GENITOURINARY		Hemophilia		Other:	□ **Y** □ **N**
Kidney or bladder problems	□ **Y** □ **N**	Anemia	□ **Y** □ **N**		
Urinary tract infections	□ **Y** □ **N**	Sickle cell disease	□ **Y** □ **N**	Is your child under the care of a specialty doctor other than their pediatrician? (If so, please list)	□ **Y** □ **N**
Pregnancy	□ **Y** □ **N**	Transfusion	□ **Y** □ **N**		
Sexually transmitted disease	□ **Y** □ **N**	Spleen abnormalities	□ **Y** □ **N**		
Other:	□ **Y** □ **N**	HIV / AIDS	□ **Y** □ **N**		
		Other:	□ **Y** □ **N**		

DENTAL HISTORY

Date of last dental visit:_____ Date of last dental radiographs (x-rays):_____	
Is there any history of injury to teeth and / or jaws?	□ **Y** □ **N**
Is your child currently experiencing dental pain?	□ **Y** □ **N**
Is there any history of dental infections?	□ **Y** □ **N**
Does your child have any oral habits? (finger sucking, tongue thrusting, tooth grinding, clenching, etc.)	□ **Y** □ **N**

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in their health history or medication, I will inform the doctor at the next appointment without fail.

Parent / Guardian Signature:_____ **Date:**_____