SUNSHINE
DENTAL ANESTHESIA

Patient's Name _____ Today's Date _____

#	QUESTIONS	ANSWERS	DOCTOR INITIALS
(1.)	When is the last time your child ate any solid food(s)?	_____ *am / pm*	
(2.)	When is the last time your child drank any clear fluid(s)?	_____ *am / pm*	
(3.)	When was the last time your child was seen by a physician?		
	What was this doctor's visit for?	☐ Wellness Check ☐ Pre-Anesthetic Evaluation ☐ Other:	
(4.)	Does your child have any medical conditions?	☐ Yes ☐ No (If yes, list conditions)	
(5.)	Please list any oral, injected or inhaled medications that your child takes on a regular basis.	☐ None	
(6.)	Does your child have any latex, adhesive, drug, food, dye or seasonal allergies or sensitivities?	☐ Yes ☐ No (If yes, list allergies)	
(7.)	Has your child been hospitalized during the last 12-months?	☐ Yes ☐ No	
(8.)	Has your child had a recent upper respiratory infection (URI) or cold during the last 3-weeks?	☐ Yes ☐ No	
(9.)	Does your child have any trouble breathing? (i.e. asthma, snoring)	☐ Yes ☐ No	
(10)	Are there any smokers in the household?	☐ Yes ☐ No	
(10.)	Has your child or anyone in your family ever had a complication associated with general anesthesia or sedation? (i.e. malignant hyperthermia)	☐ Yes ☐ No	

As the patient's parent or legal guardian, I have provided the following information to the best of my ability and understand that severe consequences can occur should this information be inaccurate. Furthermore, I have had all questions pertaining to this upcoming general anesthetic procedure answered and I am comfortable moving forward with this care.

_____   _____ _____
Parent or Legal Guardian Signature   *Date*   *Time*