Pediatric Health History – Answer each question as completely as possible. Date of surgery_____ Surgeon_____

Name_____ Age____ Sex____ Height_____ Weight_____ lb_____

Pediatrician's Name, Address & Phone_____

Name & Phone of person to contact if case of emergency_____

Current medical diagnoses or conditions	Medicines & dosages (i.e. prescription, over-the counter & herbals)

Allergies (e.g. drugs, foods, substances, latex) and describe reaction	Previous operations or surgeries	Anesthesia	Year

Yes No Has the child ever had...

- ☐ ☐ Recent exposure to communicable or infection diseases (i.e. chicken pox, hepatitis, TB, etc.)
- ☐ ☐ A recent cough over 3 weeks duration along with coughing up blood, loss of appetite, unexplained weight loss, night sweats, fever/chills, tiring easily
- ☐ ☐ Rheumatic fever or rheumatic heart disease
- ☐ ☐ Murmurs, heart defects or irregular heart beat
- ☐ ☐ Premature birth or birth complications; Explain
  _____
  _____
- ☐ ☐ Asthma, Does he/she use an inhaler or nebulizer?
- ☐ ☐ Croup, bronchitis, or recent upper respiratory infection
- ☐ ☐ Cold or sore throat within the last 2 weeks
- ☐ ☐ Mononucleosis
- ☐ ☐ Neuromuscular disease: Explain_____
  _____
  _____
- ☐ ☐ Diabetes: How Long _____
- ☐ ☐ Epilepsy or convulsions; Date of last seizure_____
- ☐ ☐ Bleeding problems
- ☐ ☐ Anemia
- ☐ ☐ Sickle cell disease
- ☐ ☐ Gastrointestinal problems: Explain_____
  _____
  _____
  _____
- ☐ ☐ Cancer, Type_____
- ☐ ☐ Other hospitalizations: Explain_____
  _____
  _____
  _____
  _____
- ☐ ☐ Previous traumatic medical/surgical experiences; Explain_____
  _____
  _____
  _____

Yes No

- ☐ ☐ Does the child have any learning/developmental disabilities
  Explain_____
  _____
- ☐ ☐ Are the child's immunizations current (DPT, MMR, Chicken Pox hepatitis-B, polio, etc.
- ☐ ☐ Has the child taken cortisone or steroids in the past year
- ☐ ☐ Is the child allergic to eggs or soybeans
- ☐ ☐ Has the child started menstruating? If yes, date of last menstrual period: _____
- ☐ ☐ Does the child have difficulties opening his/her mouth
- ☐ ☐ Has the child had a fractured nose or blocked nasal passage
- ☐ ☐ Has the child had a nose bleed that required doctor's care

After anesthesia has the child experienced any of the following

- ☐ ☐ Severe nausea or vomiting, difficulty waking up, difficulty breathing, High temperature, heart problems: Explain_____
  _____
  _____
- ☐ ☐ Has a blood relative ever had problems with anesthesia:
  Explain:_____
  _____
  _____

Does the child have (circle all that apply):

- ☐ ☐ Capped teeth, crown, permanent bridge, braces or loose teeth
- ☐ ☐ Retainers or dental implants
- ☐ ☐ Contact lenses or glasses
- ☐ ☐ Any implants or prosthesis (i.e. heart valve, screws/pins, artificial limbs, hearing aid, etc):
  Explain:_____
- ☐ ☐ Need assistance for walking: Explain_____
  _____
  _____
- ☐ ☐ Do the child have any other impairments/disabilities; Explain
  _____
  _____

*To the best of my knowledge this information is correct:*_____
Patient/Guardian *Relationship* *Date*

For Hospital Use Only *For Hospital Use Only* *For Hospital Use Only*

*Anesthesia Comments*_____
_____
_____

*Reviewed by*_____ *Date*____
*Anesthesiologist*_____ *Date*____

*Nursing Comments*_____
_____
_____

Interview ☐ Personal ☐ Phone
*Nurse*_____ *Date*