PATIENT'S MEDICAL HISTORY

(To be filled out by parent or guardian)

Name:_____
Last Name First Name

MR#: _____

Date: _____

HISTORY (Anesthesia, Surgery, Medication, Allergies) **Please explain any YES answers in detailed description in the box provided.**		
Has the patient ever had any surgery or been hospitalized?	❑Yes ❑ No	
Has the patient ever had either general anesthesia or sedation?	❑Yes ❑ No	
Is there a family history of problems with anesthesia?	❑Yes ❑ No	
Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	❑Yes ❑ No	(include dosage)
Does the patient have any allergies (including environmental, medication, food, reaction to previous blood transfusion)?	❑Yes ❑ No	
Is the patient up to date with immunizations?	❑Yes ❑ No	

FAMILY HISTORY

Please indicate if the patient's parents, grandparents, brothers or sisters, have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient
Birth Defects		Urinary/Kidney Problems	
Stomach/Intestinal Problems		Bleeding Problems (Sickle Cell)	
Breathing Problems		Heart Disease	
Hernia		OTHER	

SOCIAL HISTORY: **Patient lives with: ❑ Parent/(s) ❑ Caregiver ❑ Other: _____**

MEDICAL HISTORY

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided.

BIRTH HISTORY: ❑ Normal-full term ❑ Caesarean ❑ Premature	❑ Normal ❑ Other/Details:	**GASTROINTESTINAL:** ❑ Diarrhea ❑ Constipation ❑ Vomiting ❑ GE Reflux	❑ Normal ❑ Other/Details:
PREMATURITY: ❑ Apnea ❑ Bradycardia ❑ Intubation ❑ ROP(Retinopathy) ❑ Mechanical Ventilation ❑ BPD (Bronchopulmonary Dysplasia)	❑ Normal ❑ Other/Details:	**EAR, NOSE & THROAT:** ❑ URI (Upper Respiratory Infection)/Cold ❑ Loose Teeth ❑ Braces ❑ Deafness ❑ Removable Oral Appliance ❑ Blindness ❑ Snoring ❑ Ear Infection ❑ Nosebleeds ❑ Dysphagia (Difficulty Swallowing)	❑ Normal ❑ Other/Details:
CARDIAC: ❑ Blood Pressure Problems ❑ Arrhythmia's (Irregular Heartbeat) ❑ Cardiotoxic Drugs ❑ Palpitations ❑ Congenital Abnormality ❑ Murmurs	❑ Normal ❑ Other/Details:	**MUSCULOSKELETAL:** ❑ Muscle Disease ❑ Scoliosis ❑ Arthritis ❑ Fractures ❑ Muscular Dystrophy ❑ Neck Pain ❑ Back Pain ❑ Hypotonia	❑ Normal ❑ Other/Details:
RESPIRATORY: ❑ Asthma ❑ TB ❑ Croup ❑ Pneumonia ❑ Bronchitis ❑ Aspiration ❑ Chronic cough ❑ Tracheostomy ❑ RSV (Respiratory Syncytial Virus)	❑ Normal ❑ Other/Details:	**BLOOD DISORDERS:** ❑ Bleeding Disorder ❑ Sickle Cell Disease ❑ G6PD Deficiency ❑ Prior Transfusion ❑ Anemia ❑ Lymphoma ❑ Leukemia ❑ Thalassemia ❑ Easy Bleeding/Bruising	❑ Normal ❑ Other/Details:
GENITOURINARY: ❑ Kidney Disease ❑ UTI (Urinary Tract Infection)	❑ Normal ❑ Other/Details:	**SKIN:** ❑ Rash ❑ Birthmarks ❑ Bruises ❑ Eczema ❑ Scars ❑ Hemangioma	❑ Normal ❑ Other/Details:
HEPATIC: ❑ Liver Disease ❑ Jaundice (yellow skin) ❑ Hepatitis	❑ Normal ❑ Other/Details:	**ENDOCRINE/METABOLIC:** ❑ Diabetes ❑ Inborn Errors of Metabolism ❑ Thyroid Disorders ❑ Adrenal Disorders	❑ Normal ❑ Other/Details:
NEUROLOGIC: ❑ Seizures ❑ IVH ❑ Weakness ❑ Migraines ❑ Epilepsy ❑ Myopathy ❑ Hydrocephalus	❑ Normal ❑ Other/Details:	**PSYCHOSOCIAL:** ❑ Developmental Delay ❑ Substance Abuse ❑ Learning Disability ❑ ADD ❑ Autism	❑ Normal ❑ Other/Details:
PAIN: ❑ No ❑ Yes Intensity/Location:			

Person Completing This Form/ Relationship To Patient