



PRE-OPERATIVE HEALTH HISTORY

NAME: _____
LAST FIRST M.I.

DATE OF BIRTH: _____ AGE: _____ SEX: _____ PHONE #: () _____

NAME OF CHILD'S PEDIATRICIAN: _____

PEDIATRICIAN'S ADDRESS: _____

PEDIATRICIAN'S PHONE #: () _____

PARENT OR LEGAL GUARDIAN'S NAME: _____

IF NOT PARENT, PLEASE STATE RELATIONSHIP TO CHILD: _____

PLEASE BRING ANY LEGAL GUARDIANSHIP PAPERS YOU HAVE WITH YOU ON THE DAY OF SURGERY.

PLEASE CIRCLE THE CORRECT ANSWERS

1. IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? (FOR EXAMPLE, HAS ANY MEDICATION EVER CAUSED YOUR CHILD TO WHEEZE OR DEVELOP A RASH) YES NO

1a. IF YES, PLEASE LIST ALL MEDICATIONS YOUR CHILD IS ALLERGIC OR SENSITIVE TO AND THE REACTIONS:

2. IS YOUR CHILD ALLERGIC TO LATEX (RUBBER)? YES NO
IF YES, PLEASE SPECIFY TYPE OF REACTION: _____

3. DOES YOUR CHILD HAVE ANY FOOD ALLERGIES? YES NO
IF YES, PLEASE LIST FOOD(S) AND TYPE OF REACTION: _____

4. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS INCLUDING EYE DROPS? YES NO
IF YES, PLEASE LIST THEIR NAMES, DOSE AND FREQUENCY:

NAME OF MEDICATION	DOSE TAKEN	HOW OFTEN	NAME OF MEDICATION	DOSE TAKEN	HOW OFTEN

IS YOUR CHILD TAKING INSULIN? YES NO

IF YES, WHAT TYPE _____ HOW MUCH? _____

5. DOES YOUR CHILD HAVE A HISTORY OF:
- | | | | | | |
|--|-----|----|---------------------------------|-----|----|
| (a) HEART MURMUR OR IRREGULAR HEART BEAT | YES | NO | (e) SEIZURE DISORDER | YES | NO |
| (b) CYANOTIC HEART DISEASE | YES | NO | (f) KIDNEY DISEASE | YES | NO |
| (c) BREATHING PROBLEMS, BRONCHITIS OR ASTHMA | YES | NO | (g) BLEEDING PROBLEM | YES | NO |
| (d) DIABETES | YES | NO | (h) HEPATITIS | YES | NO |
| | | | (i) OTHER MEDICAL PROBLEM _____ | YES | NO |

IF YES TO ANY OF ABOVE, PLEASE SPECIFY _____

6. PLEASE GIVE YOUR CHILD'S WEIGHT _____ HEIGHT _____

7. HAS YOUR CHILD BEEN EXPOSED TO CHICKEN POX WITHIN THE PAST MONTH? YES NO

8. ACCORDING TO THE NEW YORK STATE DEPARTMENT OF HEALTH, CHILDREN BETWEEN THE AGES OF SIX MONTHS AND SIX YEARS SHOULD HAVE A BLOOD TEST TO SCREEN FOR LEAD.

HAS YOUR CHILD BEEN TESTED? YES NO NA (DUE TO CHILD'S AGE)
IF NO, PLEASE DISCUSS THIS WITH YOUR CHILD'S PEDIATRICIAN

9. PERINATAL HISTORY

WAS THE PREGNANCY COMPLICATED? YES NO

WAS THE CHILD PREMATURE? YES NO

IF YES, HOW MANY WEEKS? _____

WERE THERE PROBLEMS IN INFANCY? YES NO

IF YES, WHAT? _____

HOSPITALIZATIONS? _____

10. LIST ALL PREVIOUS SURGERIES; INCLUDE DATES

11. HAS YOUR CHILD OR ANY MEMBER OF YOUR IMMEDIATE FAMILY HAD ANY PROBLEMS CONNECTED WITH ANESTHESIA OR OPERATIONS, SUCH AS MALIGNANT HYPERTHERMIA?

YES NO

IF YES, PLEASE SPECIFY INCLUDING WHEN AND WHERE _____

12. HAS YOUR CHILD BEEN HOSPITALIZED IN THE PAST YEAR? YES NO

IF YES, PLEASE SPECIFY? _____

13. DOES YOUR CHILD HAVE ANY LOOSE, BROKEN, CAPPED TEETH OR BRACES? YES NO

14. DO YOU OR YOUR CHILD HAVE ANY CONCERNS OR SPECIAL PROBLEMS THAT WE SHOULD BE AWARE OF? YES NO

IF YES, PLEASE EXPLAIN _____

(PLEASE BE AWARE OF OUR CURRENT LOCATION AT 1065 SENATOR KEATING BLVD. A MAP IS PROVIDED WITH YOUR WESTFALL INFORMATION)

DATE

SIGNATURE OF PARENT OR GUARDIAN

DO NOT WRITE BELOW THIS LINE

PATIENT HISTORY FORM REVIEWED BY _____ RN DATE _____

COMMENTS: (If Appropriate) _____

DATE

SIGNATURE