Pediatric / Teen Health Questionnaire

Patient Name: _____ DOB: _____Age: _____Sex: _____

Guardian Name/Relationship: _____ Height: _____ Weight: _____

Primary Phone #: _____ Alternate #: _____

Physician Name and #: _____ Date of Last Physical: _____

Does the patient have or had any of the following?

□ Yes □ No Allergies? (Food, Medications, Latex, Seasonal, etc.) What Happens?
_____

□ Yes □ No Medications? (Prescriptions, Inhalers, Over-the-counter, Vitamins)
_____

□ Yes □ No Previous ER Visit or Hospitalization? When and Why?
_____

□ Yes □ No Cold / Cough / Flu in the Past 6 Weeks? When? _____

□ Yes □ No Medical Specialists? Cardiology / ENT / Neurology / Pulmonology / Gastroenterology / Endocrinology Hematology / Psych / Other:_____

□ Yes □ No Special Medical Tests for any Reason? _____

□ Yes □ No Family History of Malignant Hyperthermia or Problems with Anesthesia?

□ Yes □ No Immunizations up to Date?

□ Yes □ No Premature Birth? How Many Weeks at Birth? _____

□ Yes □ No Any delays in development? (Crawling, walking, talking, or other milestones) _____

□ Yes □ No Snoring at night?

□ Yes □ No Any changes in the patient's health in the past year?_____

□ Yes □ No Are there any Behavioral / Emotional / Cultural / Spiritual concerns that we need to be aware of?
_____

Has your child ever experienced any of the following? Please check the box if YES:

□ Asthma, Wheezing, Shortness of breath
□ Pneumonia, Bronchitis, Chronic Cough
□ Head & Neck injury or trauma
□ Complications at birth
□ Croup (barking cough), Stridor
□ Sleep Apnea (stops breathing while asleep)
□ Cancer, Tumor, Chemotherapy, Radiation therapy
□ Thyroid Disease, Adrenal gland problems
□ Fainting spells or Blackouts
□ Hiatal Hernia, Heartburn, Acid Reflux, Indigestion
□ Heart Murmur
□ Stomach/intestinal problems (ulcers/bleeding, other)
□ Congenital Heart Defect
□ Atrial or Ventricular septal defect
□ Swallowing Difficulties, Choking episodes
□ Irregular Heart Beat, Palpitations, Arrhythmia
□ Genetic Disorder, Congenital Abnormalities
□ Heart Disease, High or Low Blood Pressure
□ Seizure or Epilepsy / Convulsions
□ Rheumatic Fever /Scarlet Fever
□ Kidney Disease, Bladder Disorders
□ Bleeding Problems, Easy Bruising, Clotting Issues
□ Liver Disease (Jaundice or Hepatitis, other)
□ Anemia (Including Sickle Cell Anemia)
□ Diabetes, Nutritional Disorders
□ Blood Transfusions
□ Organ transplant/ Bleeding disorder
□ Auto-immune disease/suppressed immune system
□ ADD or ADHD, Autism (circle one or more)
□ Muscle Disease (Muscular Dystrophy, others)
□ HIV/AIDS
□ Other: _____

I understand that withholding any information about the patient's health could seriously jeopardize his/her safety during anesthesia. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge.

Name: _____ Signature: _____ Date: _____
(Parent or Legal Guardian)