

PATIENT HISTORY

PEDIATRIC SURGICAL ASSOCIATES

TODAY'S DATE _____ / _____ / _____

Name: _____
First Middle Last

Birth Date: _____ / _____ / _____

Birth Weight: _____ Current Weight: _____

Male / Female

Primary Care Doctor: _____

CHIEF COMPLAINT (IN YOUR OWN WORDS WHAT IS YOUR CHILD'S CONDITION?): _____

NEONATAL HISTORY

_____ PREMATURITY (GESTATIONAL AGE _____ WEEKS)

_____ RESPIRATORY PROBLEMS

_____ FEEDING DISORDERS

_____ HEART DISEASE

_____ OTHER

_____ JAUNDICE

_____ OTHER

LIST OTHER SIGNIFICANT MEDICAL PROBLEMS: _____

RECENT EXPOSURE TO COMMUNICABLE DISEASES:

DISEASE	APPROXIMATE EXPOSURE DATE
_____ MEASLES	_____
_____ CHICKEN POX	_____
_____ TUBERCULOSIS	_____
_____ OTHER	_____

If more room is needed when listing medical problems, medications, allergies, hospitalizations and surgeries please attach a separate sheet.

LIST ANY MEDICATIONS CURRENTLY TAKING: _____

LIST DRUG ALLERGIES AND TYPE OF REACTION: _____

LIST PREVIOUS HOSPITALIZATION (DATES AND REASONS): _____

LIST PREVIOUS SURGERIES: _____

HAS YOUR CHILD HAD A PROBLEM WITH GENERAL ANESTHESIA?

NO YES EXPLAIN: _____

DOES YOUR CHILD HAVE ANY PROBLEMS WITH BLEEDING?

NO YES EXPLAIN: _____

HAS YOUR CHILD HAD TRANSFUSIONS? NO YES HOW MANY? _____

IF SO FOR WHAT REASON? _____

WHAT IS YOUR CHILD'S DIET? (INDICATE TYPE OF MILK OR FORMULA, VOLUME AND FREQUENCY): _____