PATIENT HISTORY *PEDIATRIC SURGICAL ASSOCIATES*

TODAY'S DATE ____ / ____ / ____

Name: _____ Birth Date: ____ / ____ / ____
First Middle Last

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): _____