Pediatric Surgery Medical History Report

Patient's Name: ___________________________________ DOB: ____/____/____ Today's Date: ____/____/____
Last Name, First Name

Child's Past Medical History – Please mark ALL that apply

Birth History

Pregnancy: __Uncomplicated __Complications________________________________

Delivery: __Full Term __Pre-Term (weeks premature_____)

Birth Weight: _____lbs____oz

Newborn History

Did your child remain hospitalized over 24 hours after birth? __No __Yes, how long?_________

Hospitalized for:

__Prematurity __Feeding Problems __Breathing Problems (req'd Oxygen or Breathing Machine)
__Heart Problems, defects __ASD __VSD __PDA Other________________________
__Neurologic Problem: __Cerebral Palsy Other_________________________
__Infections, what kind? ____

Previous Medical History

Does your child have any known syndrome? __No __Yes, please circle syndrome name-

Down Turner's VATER's Other__________________

Is your child allergic to any medications? __No ___ Yes, please complete on back of page

Does your child take any medications regularly? __No ___ Yes, please complete on back of page

Has your child been hospitalized for any illness or injury? __No ___ Yes, please complete on back of page

Has your child had any previous surgeries? __No ___ Yes, please complete on back of page

Has your child or anyone in your family experienced any difficulty with anesthesia? __No __Yes
Is there a family history of bleeding problems? __No __Yes
Are your child's immunizations up to date? __No __Yes

Does your child have any other medical problems or special needs not listed above?

Please Circle:

General	Recent weight loss	Y N	Heart	Murmurs?	Y N
	Fevers	Y N		Racing Heart?	Y N
	Night sweats	Y N		Chest pain?	Y N
Head	Runny Nose	Y N	GI	Diarrhea?	Y N
	Earaches	Y N		Constipation?	Y N
	Sore throat	Y N		Vomiting?	Y N
	Nose bleeds	Y N		Blood in stool?	Y N
Lungs	Coughing	Y N	Urinary	Painful Urination?	Y N
	Asthma	Y N		Blood in Urine?	Y N
	Shortness of Breath	Y N		Urinary Infection?	Y N
Neurologic	Seizures	Y N	Heme	Easy Bruising?	Y N
	Head Injury?	Y N		Bleeding Gums?	Y N
	Difficulty walking?	Y N		Swollen joints?	Y N

Name of Medication child is allergic and type of reaction to the medication:

Please List Child's Medications:

Medication	Dose
Medication	Dose
Medication	Dose
Medication	Dose
Medication	Dose

Hospitalizations:

Illness/Injury	Hospital	Date
Illness/Injury	Hospital	Date
Illness/Injury	Hospital	Date

Surgery(ies):

Surgery	Hospital	Date
Surgery	Hospital	Date

Completed / Updated by:

____________________ Date(s): ____________

Reviewed by:

____________________ Date(s): ____________

Physician's signature