SAS Pediatric Medical History

Date_______________

Child's Full Name ____
DOB____/____/______ Age __________
Gender: □ M □ F Height _______ Weight: _______ lb or kg (Please circle)

Name/address/phone of primary physician ____
Date of last appt_______________
Name/address/phone of medical specialists:
____

1) Is your child being treated by a physician at this time? Reason ___________________________ □ Yes □ No
2) Has your child been ill in the past 6 weeks? Describe ___________________________ □ Yes □ No
3) Is your child taking any medication (prescription/over-the-counter), vitamins, or dietary supplements □ Yes □ No
List name, dose, frequency, and date started: ___________________________
4) Has your child ever been hospitalized, had surgery or significant injury, or been treated in an ER? □ Yes □ No
List date and describe: ___________________________
5) Has your child, or family members, ever had a reaction to or problem with an anesthetic? □ Yes □ No
Describe: ___________________________
6) Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? □ Yes □ No
List ___________________________
7) Is your child allergic to latex or anything else, such as metals, acrylic, dyes, or foods? □ Yes □ No
List ___________________________
8) Is your child up to date on immunizations against childhood diseases? ……………………………………. □ Yes □ No

Please mark YES if your child has a history of the following conditions. For each "Yes", provide details at the end of this form.
Mark NO after each line if the conditions do not apply to your child.

9) Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions □ Yes □ No
10) Problems with physical growth or development ………………………………………………………… □ Yes □ No

11) Sinusitis, chronic adenoid/tonsil infections ………………………………………………………………… □ Yes □ No
12) Sleep apnea/snoring, mouth breathing, or excessive gagging ………………………………………………. □ Yes □ No

13) Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease …………□ Yes □ No
14) Irregular heart beat or high blood pressure ……………………………………………………………………. □ Yes □ No

15) Asthma, reactive airway disease, wheezing, or breathing problems …………………………………….. □ Yes □ No
16) Cystic fibrosis ………………………………………………………………………………………………….. □ Yes □ No
17) Frequent colds or coughs, or pneumonia ………………………………………………………………………. □ Yes □ No
18) Frequent exposure to tobacco smoke …………………………………………………………………………… □ Yes □ No

19) Jaundice, hepatitis, or liver problems …………………………………………………………………………. □ Yes □ No
20) Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ………………… □ Yes □ No
21) Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions …………………… □ Yes □ No
22) Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder …………… □ Yes □ No

23) Bladder or kidney problems ……………………………………………………………………………………. □ Yes □ No

24) Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ……………………… □ Yes □ No

25) Rash/hives, eczema, or skin problems ………………………………………………………………………. □ Yes □ No

26) Impaired vision, hearing, or speech …………………………………………………………………………. □ Yes □ No
27) Developmental disorders, learning problems/delays, or intellectual disability ……………………….. □ Yes □ No
28) Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ………………………………………… □ Yes □ No
29) Autism/autism spectrum disorder ……………………………………………………………………………. □ Yes □ No
30) Recurrent or frequent headaches/migraines, fainting, or dizziness ………………………………………. □ Yes □ No
31) Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)…… □ Yes □ No

32) Attention deficit/hyperactivity disorder (ADD/ADHD) ………………………………………………… □ Yes □ No
33) Behavioral, emotional, communication, or psychiatric problems/treatment …………………………… □ Yes □ No
34) Abuse (physical, psychological, emotional, or sexual) or neglect ………………………………………… □ Yes □ No

35) Diabetes, hyperglycemia, or hypoglycemia ……………………………………………………………… □ Yes □ No
36) Precocious puberty or hormonal problems ……………………………………………………………… □ Yes □ No
37) Thyroid or pituitary problems …………………………………………………………………………… □ Yes □ No

38) Anemia, sickle cell disease/trait, or blood disorder ………………………………………………….. □ Yes □ No
39) Hemophilia, bruising easily, or excessive bleeding ……………………………………………….. □ Yes □ No
40) Transfusions or receiving blood products …………………………………………………………….. □ Yes □ No
41) Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow/organ transplant □ Yes □ No

42) Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV/AIDS) …□ Yes □ No

PROVIDE DETAILS HERE: ____

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Is there any other significant medical history **pertaining to this child or his/her family** that we should know? □ Yes □ No

Describe: ____

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Taken from AAPD
3/13/18

Patient Instruction Sheet - Pediatric

Your child will be receiving intravenous medications during his/her operative procedure. It is therefore very important that you adhere to the following instructions. If there are any questions, please don't hesitate to call for further directions: (316) 788-5939.

If your child has a prescription for breathing treatments, please bring his/her medication and nebulizer the day of the procedure.

1) No food for **eight hours** prior to your arrival at the office. Your child may have clear liquids (doesn't include milk) up to **three hours** prior to his/her procedure. Once within the 3-hr window prior to the appointment, absolutely nothing goes in the mouth (do NOT even brush the teeth!). **It is essential for your child's safety that you strictly adhere to this policy. To do otherwise can put the child in danger of severe lung damage or death.**

2) Dress the child in comfortable clothing, preferably a shirt or blouse with short sleeves. Younger children will occasionally become relaxed enough to lose bladder control. **You may want to consider a diaper, pull-up, or a change of clothing.**

3) Remove fingernail polish from at least one fingernail on each hand.

4) Children require extra care during transportation home from their procedure. **It is highly recommended that two adults accompany the child so the driver does not have to attend to the child in transit.**

5) After your child's surgery, wait until the next day before allowing him/her to engage in any activity in which a decrease in alertness, judgement, or coordination could cause a problem.

6) After surgery, your child may take pain medication as directed by the surgeon.

I have read the above instructions, they are clear to me, and I agree to comply.

____________________________	____
Patient	Signature of patient or responsible party

Please fax or send completed forms to our office as soon as possible prior to the date of service. Your cooperation will enhance the safety of this procedure and is appreciated.