Ambulatory Surgery Center of Western New York
945 Sweet Home Road, Amherst, New York 14226

PEDIATRIC HEALTH HISTORY

FORM TO BE COMPLETED BY PATIENT'S PARENT/GUARDIAN
FOR PATIENTS UNDER THE AGE OF 18

PLEASE PRINT Patient Name_____
Patient Address_____
Patient Phone#_____Emergency Contact/ Phone #_____
Patient DOB_____

Patient Race: Caucasian African American Hispanic Asian Native American
PRIMARY CARE PHYSICIAN NAME_____
ADDRESS OF PRIMARY PHYSICIAN_____
PHONE NUMBER OF PRIMARY PHYSICIAN_____

Height_____ Weight_____

DO NOT WRITE BELOW THIS LINE

SCHEDULED PROCEDURE:				
BLOOD PRESSURE	TEMP	PULSE	RESP	SaO2 on room air
1. CONSENT FORM SIGNED/DATED/WITNESSED 2. NPO 3. PATIENT TEACHING COMPLETED 4. I.D. BAND DOB PROCEDURE REVIEWED WITH PATIENT/GUARDIAN				NURSES NOTES: _____ _____ _____ _____

	YES	NO	DESCRIPTION	
CONTACT LENSES				
DENTURES				
HEARING AID				

NURSING DIAGNOSIS: Potential for anxiety, patient knowledge deficit. GOAL: Decrease patient anxiety through education

Skin Condition:	LOC:
intact pale warm flushed diaphoretic cool	alert sedated agitated confused oriented anxious unresponsive

TRANSPORTED TO OR VIA: AMBULATORY WITH ASSIST WHEELCHAIR STRETCHER

NURSES SIGNATURE:_____

Ambulatory Surgery Center of Western New York
Pediatric Anesthesia Questionaire

Please check one answer to each question.

	Yes	No	Don't Know
1. Has your child ever been in this facility before?	☐	☐	☐
2. Has your child ever been in a hospital?	☐	☐	☐
3. Has your child ever had an anesthetic?	☐	☐	☐
4. Did your child have any problems with the anesthetic?	☐	☐	☐
5. Does your child have any allergies?	☐	☐	☐
6. Was the allergy due to:	☐	☐	☐
a) a drug or medicine?			
b) any type of food?			
c) other things?			
7. If your child had an allergy, did he/she have:			
a) a skin rash or hives?			
b) wheezing or trouble breathing?			
c) hay fever or runny nose?			
d) a high fever?			
8. Has your child had a head cold or cough within the past week?	☐	☐	☐
9. Does your child wear a dental plate or bridge?	☐	☐	☐
10. Does your child have any loose teeth?	☐	☐	☐
11. Has your child had a cortisone type drug within the past two years?	☐	☐	☐
12. Is your child receiving any medicine now?	☐	☐	☐

	Yes	No	Don't Know
13. Is there anyone in the family with a bleeding problem?	☐	☐	☐
14. Has the patient had any minor injuries, operations, or tooth extraction followed by an unusual amount of bleeding?	☐	☐	☐
15. Does your child bruise easily on body areas other than the legs?	☐	☐	☐
16. Has your child been exposed to any infectious disease within the past month? (example: chicken pox, measles, mumps)	☐	☐	☐
17. Was your child premature?	☐	☐	☐
18. Has your child ever had:			
Diabetes	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Respiratory Illness	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Rheumatism	☐	☐	☐
Heart Disease/ Murmur	☐	☐	☐
Liver Disease	☐	☐	☐
Anemia	☐	☐	☐
Convulsions or Seizures	☐	☐	☐
Glaucoma	☐	☐	☐
Jaundice	☐	☐	☐
Sleep Apnea	☐	☐	☐
19. Is there any problems about your child not mentioned so far?	☐	☐	☐
20. Has anyone in your family ever had a problem with an anesthetic?	☐	☐	☐

If any questions above received a "Yes" answer give details below :

Date Completed:

Signature of Parent: