

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 <input type="checkbox"/> 2. NPO <input type="checkbox"/> 3. PATIENT TEACHING COMPLETED <input type="checkbox"/> 4. I.D. BAND <input type="checkbox"/> DOB <input type="checkbox"/> PROCEDURE REVIEWED WITH PATIENT/GUARDIAN <input type="checkbox"/>				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: <input type="checkbox"/> intact <input type="checkbox"/> pale <input type="checkbox"/> warm <input type="checkbox"/> flushed <input type="checkbox"/> diaphoretic <input type="checkbox"/> cool			LOC: <input type="checkbox"/> alert <input type="checkbox"/> sedated <input type="checkbox"/> agitated <input type="checkbox"/> confused <input type="checkbox"/> oriented <input type="checkbox"/> anxious <input type="checkbox"/> unresponsive	
TRANSPORTED TO OR VIA: AMBULATORY WITH ASSIST <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> STRETCHER <input type="checkbox"/>				
NURSES SIGNATURE: _____				

Ambulatory Surgery Center of Western New York Pediatric Anesthesia Questionnaire

Please check one answer to each question.

	Yes	No	Don't Know		Yes	No	Don't Know
1. Has your child ever been in this facility before?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Is there anyone in the family with a bleeding problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child ever been in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Has the patient had any minor injuries, operations, or tooth extraction followed by an unusual amount of bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had an anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Does your child bruise easily on body areas other than the legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Did your child have any problems with the anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Has your child been exposed to any infectious disease within the past month? (example: chicken pox, measles, mumps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Was your child premature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Was the allergy due to: a) a drug or medicine? b) any type of food? c) other things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Has your child ever had:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your child had a head cold or cough within the past week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child wear a dental plate or bridge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your child have any loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has your child had a cortisone type drug within the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is your child receiving any medicine now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Heart Disease/ Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				19. Is there any problems about your child not mentioned so far?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				20. Has anyone in your family ever had a problem with an anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If any questions above received a "Yes" answer give details below :							
Date Completed:				Signature of Parent:			