Ambulatory Surgery Center of Western New York
3112 Sheridan Drive, Amherst, New York 14226

PEDIATRIC HEALTH HISTORY

FORM TO BE COMPLETED BY PATIENT'S PARENT/GUARDIAN

PATIENT NAME:_____

PARENT/GUARDIAN NAME :_____

PRIMARY CARE PHYSICIAN:_____

PHONE NUMBER OF PRIMARY CARE 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:
☐ intact ☐pale ☐warm
☐ flushed ☐diaphoretic ☐cool

LOC:
☐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?	☐	☐	☐
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: