Specialty Anesthesia Partners
SleepThruIt.com

Pediatric Medical History Form

Today's Date: _____ / _____ /_____
MM DD YYYY

Patient Identification

Patient Name:_____
(First Name) (Middle Name) (Last Name)

DATE OF BIRTH: _____ / _____ /_____
MM DD YYYY

SEX: ☐ Male ☐ Female ☐ Other:_____

Current **HEIGHT**:_____ Current **WEIGHT**:_____

RACE: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/ African American ☐Native Hawaiian/ Pacific Islander ☐ White/ Caucasian ☐ Other:_____

ETHNICITY: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Other:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

PARENT/GUARDIAN INFORMATION

Child is in the **legal custodial care** of: ☐ Mother Only ☐ Father Only ☐ Both Parents ☐ Other_____

Parent/Guardian/Custodian AND Primary Contact

Name:_____

Relationship: _____
Address:_____
_____

Phone:_____
Email:_____

Parent/Guardian 2 / Secondary Contact:

Name:_____

Relationship:_____
Address: _____
_____

Phone:_____
Email:_____

ADDITONAL EMERGENCY CONTACT (OTHER THAN PRIMARY AND SECONDARY CONTACT)

Name: _____Relationship: _____Phone:_____

MEDICAL HISTORY

Pediatrician name: _____ Phone: _____
Specialist Name & type: _____ Phone: _____

1. Is your child in good health?	**Yes**	**No**
2. Has there been any change in your child's health in the last year?	**Yes**	**No**
3. Is your child currently under the care of a physician for any condition?	**Yes**	**No**
4. With regards to your child's birth history:		
Was your child PREMATURE (< 37 weeks)?	**Yes**	**No**
Did your Child require NICU or Critical Care at birth?	**Yes**	**No**

MEDICATIONS

5. Does your child currently take any prescriptions, over the counter medication, or supplements?	**Yes**	**No**

If yes, please list all medications, over the counter medications, and supplements AND dosages

_____
_____

Allergies:

6. Does your child have any allergies to drugs or medications?	**Yes**	**No**

If yes, please list with reactions:_____

7. Does your child have any environmental, food, or latex allergies?	**Yes**	**No**

If yes, please provide details:_____

8. Please check if your child HAS or EVER HAD any of the following medical conditions:
If no problems in that area, please check "none"

Cardiac	Respiratory	Neurological/Muscular
☐ Heart murmur	☐ Asthma or Reactive Airway	☐ Stroke
☐ Congenital Heart Defect/Disease	☐ Pulmonary Fibrosis	☐ Seizure or Epilepsy
☐ Long QT syndrome	☐ Bronchitis	☐ Brain Disease or condition
☐ Arrythmia or Irregular Heartbeat	☐ Pneumonia	☐ Spinal Cord disease or injury
☐ Cardiac arrest	☐ Pneumothorax	☐ Nervous system disease
☐ MI or Heart Attack or Angina	☐ Pulmonary embolism	☐ Muscular dystrophy
☐ Pacemaker/defibrillator	☐ Pulmonary Edema	☐ Neuromuscular problem
☐ Heart Valve disease/disorder	☐ Tracheal Esophageal Fistula	☐ Cerebral Palsy
☐ Pacemaker/defibrillator	☐ Aspiration	☐ Autonomic Dysreflexia
☐ Hypertension or Hypotension	☐ Tuberculosis	☐ Spinal Bifida
☐ LVAD	☐ Chronic Cough	☐ Hydrocephalus or VP shunt
☐ Coronary Artery Disease	☐ Interstitial Lung Disease	☐ Paralysis
☐ Heart Failure		☐ Rhabdomyolysis/myolosis
☐ Other_____	☐ Other_____	☐ Other_____
☐ None	☐ None	☐ None

Head and Neck	Blood and Vascular	Endocrine
☐ Tracheostomy	☐ Iron Deficiency Anemia	☐ Diabetes
☐ Tracheal Stenosis/Malacia	☐ Sickle Cell Anemia or Trait	☐ Thyroid disease
☐ Cleft Lip or Cleft Palate	☐ Aneurysm	☐ Hormone disorder
☐ Obstructive Sleep Apnea	☐ Vasculitis or Kawasaki disease	☐ Adrenal Insufficiency
☐ Enlarged Tonsils or Adenoids	☐ Hemophilia or Van Willebrand's	☐ Growth Disorder
☐ Nasal Disorder	☐ Bleeding or Clotting Disorder	☐ Bone problems or disease
☐ Craniofacial Disorder	☐ Thrombosis or Embolism	☐ Pituitary/Hypothalamus disease
☐ Recurrent ear infections	☐ Porphyria	☐ Obesity
☐ Rhinitis or Sinus disease	☐ Carotid stenosis	☐ Sleep disorder
☐ Eye Disease	☐ Peripheral Vascular Disease	
☐ Other_____	☐ Other_____	☐ Other_____
☐ None	☐ None	☐ None

GIU	Psychiatric	Genetic and Systemic
☐ GERD or Reflux disease	☐ ADD/ADHD	☐ Down Syndrome
☐ Esophagitis	☐ Autism	☐ Genetic syndrome or disorder
☐ Ulcers	☐ Behavioral Disorder	☐ Mitochondrial disorders
☐ G-tube or other Feeding tubes	☐ Intellectual Disability	☐ Physical disorder
☐ Gastro-Intestinal Disease	☐ PTSD	☐ Cancer
☐ Hepatitis	☐ Anxiety	☐ Radiation or Chemotherapy
☐ Liver Disease	☐ Psychosis	☐ Burn History
☐ Liver Failure or Cirrhosis	☐ Neurodevelopmental disorder	☐ Sensory disease/disorder
☐ Kidney Disease		☐ Organ transplant
☐ Dialysis		☐ HIV or Infectious Disease
☐ Other_____	☐ Other_____	☐ Other_____
☐ None	☐ None	☐ None

9. Please detail any of the above marked in question #8 OR any other/additional medical conditions your child has or had:

_____
_____
_____

HOSPITALIZATIONS AND SURGERIES

10. Has your child EVER been admitted to a Hospital OR undergone any Surgery? **Yes** **No**

If yes, please list:

Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____

SEDATION AND ANESTHESIA HISTORY

11. What is the reason your child is being referred for General Anesthesia or Sedation? (check all that apply)

☐Anxiety/Fear ☐Uncooperative Behavior ☐ Physical limitations ☐ Significant Gag Reflex
☐Extensive treatment needs ☐Medical Risk Factors ☐ Special Needs ☐ Other_____

12. Has your child ever had any Sedation or General Anesthesia for any reason? **Yes** **No**

If yes, please detail:_____

13. Did your child have any adverse reaction or complication with their anesthesia? **Yes** **No**

If yes, please detail:_____

14. Has your child ever experienced any of the following anesthesia issues:

Malignant Hyperthermia	Yes	No	Difficult intubation	Yes	No
Pseudocholinesterase problem	Yes	No	Difficult IV	Yes	No
Hospital or ICU Transfer	Yes	No	Difficult airway	Yes	No
Respiratory Problem	Yes	No	Prolonged intubation	Yes	No
Cardiac arrest	Yes	No	Delayed Awakening	Yes	No
MI or Stroke	Yes	No	Nausea and Vomiting	Yes	No
Clot or Embolism	Yes	No	Emergence Delirium	Yes	No
Anaphylaxis/Allergy	Yes	No	Physical Injury	Yes	No
Hemorrhage	Yes	No	Failed sedation	Yes	No
Nerve Injury	Yes	No	Other	Yes	No

FAMILY HISTORY

15. Do ANY BLOOD RELATIVES for the child have or ever had any of the listed problems?

Anesthesia Problems	Yes	No	Cardiomyopathy	Yes	No
Malignant Hyperthermia	Yes	No	Long QT syndrome	Yes	No
Pseudocholinesterase def.	Yes	No	Muscular Dystrophy	Yes	No
Congenital Heart Disease	Yes	No	Neuromuscular disease	Yes	No
Sudden Cardiac Death	Yes	No	Porphyria	Yes	No
Bleeding or Clotting disorder	Yes	No	Genetic condition	Yes	No
Sickle Cell Anemia Disease	Yes	No	Other	Yes	No

SOCIAL HISTORY

16. Please check any of the following that pertain to your child's social history, or check NONE if not applicable:

☐Smoking/Tobacco exposure ☐Homelessness ☐ Malnutrition / Food insecurity
☐Current Domestic Violence / requesting HELP now ☐Abuse History ☐Significant Life Hardship
☐Do Not Resuscitate Order (DNR) ☐Drug exposure ☐Not on routine vaccine schedule
☐Other:_____ ☐NONE

REVIEW OF SYSTEMS

17. Please Check box for any problems your child has. If no problems in that area now, check "no problems"

Constitutional:	☐ **no problems**
☐ Fever ☐ Chills ☐ Fatigue ☐ Unexplained weight loss/gain ☐ Excessive thirst ☐ Sleep problems	
Cardiovascular:	☐ **no problems**
☐ Chest pain ☐Palpitations ☐Exercise intolerance ☐Shortness of Breath on Exertion ☐Fast/Slow heartbeat	
Respiratory:	☐ **no problems**
☐ Cough ☐ Short of breath ☐ Chest tightness ☐ Wheeze ☐ Coughing blood	
Neurologic:	☐ **no problems**
☐ Seizures ☐ Headaches ☐Weakness ☐ Tremors ☐ Numbness ☐ Fainting ☐ Dizziness ☐ Vision changes	
Musculoskeletal:	☐ **no problems**
☐Muscle pain ☐Joint pain ☐Swelling ☐ Bone pain ☐ Neck stiffness ☐ Movement limitations	
GI/GU:	☐ **no problems**
☐ Nausea ☐vomiting ☐diarrhea ☐ Constipation ☐blood in stool ☐ Abdominal pain ☐ Changes in urination	
Ear, Nose, and Throat:	☐ **no problems**
☐ Mouth-breathing ☐ Snoring ☐ Ear pain ☐ Runny nose ☐ Nosebleeds ☐Sore throat ☐ neck masses	
Psychiatric/emotional:	☐ **no problems**
☐ Behavior changes ☐Anger/Violence ☐ Self-injurious behavior ☐ Changes in alertness or attention	
Integumentary:	☐ **no problems**
☐ itching ☐rashes ☐recent wounds ☐nodules ☐tumors ☐eczema ☐swellings ☐masses ☐Brusing	
Heme/Lymph/ID:	☐ **no problems**
☐Prior transfusion ☐Low blood cell counts ☐immune deficiency ☐infectious disease ☐Easy bleeding	
Dental:	☐ **no problems**
☐ Loose teeth ☐missing teeth ☐difficulty opening mouth ☐limited Jaw range of motion	

ATTESTATION

I certify that I have read and understood the above form.

I understand the importance of a complete and truthful health history and that my Anesthesia Care Team will rely on this information for safe treatment. I understand failure to disclose true and complete information may result in serious and/or significant health consequences. I affirm I will not hold my Dentist, Anesthesiologist, or any other member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

I affirm that the information given on this form is accurate and complete to the best of my ability.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name:_____ Relationship (if applicable)_____

I Have Reviewed and Discussed the completed Medical History Form.

Provider Signature: _____ Date: _____