

Patient's Name: _____ D.O.B _____

Referring Physician: _____

Name and Location of Pharmacy Used: _____

List all current medications, including any over the counter (OTC) medications or supplements

Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines you can not take

No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Does your child have a known allergy to any of the following?

Latex
 Iodine
 Tape
 Contrast Agents (Dye)
 Other _____
 (Please describe)

Past Health History

Please indicate any diseases or problems that you have had or been diagnosed with by a doctor

No Major Illnesses

1. Childhood Diseases

- Mumps
- Measles
- Chicken Pox
- Other _____

2. Congenital (Birth) Problems

- Down's Syndrome
- Heart Defect
- Prematurity (# of weeks _____)
- Other _____

3. Other Problems

- Sleep Apnea
- GERD / Reflux
- Diabetes
- Other _____

History of any other condition not listed?

Surgeries / Injury

Have you ever had problems with anesthesia (being put to sleep for surgery)? Yes No

Please list any surgeries your child has had.

No Surgery

Name of Operation: _____

Date: _____

Please list any admissions to a hospital other than the above.

No Hospitalization

Reason for Hospitalization: _____

Date: _____

Family History

Do any of your BLOOD RELATIVES have a history of:

Family History Unkown

Problems with Anesthesia

Hearing Loss after age 20

Hearing Loss before age 20

Heart Problems

Bleeding / Clotting Problems

Cancer

Other Major Health Problems _____
Please Describe

No family history problems known

Social History

Marital status of parents: Single Married Divorced Widowed

Is child adopted?: Yes No

Names of child's parents:

Names of child's siblings:

