



PEDIATRIC - Patient Medical History Questionnaire

NAME	D.O.B.	AGE	HEIGHT	WEIGHT	SURGEON	DATE of SURGERY

Your Child's General Health is: GOOD FAIR POOR

List All Operations &
Hospitalization With Diagnosis

YES NO Have you or anyone in your family ever had a serious problem with Anesthesia?
If YES, Please Describe _____

YES NO Has Patient recently had a fever or chills, cold or flu?
If YES, Please Describe _____

YES NO Loose Teeth?

YES NO Disease that runs in the family?
If YES, Please Describe _____

YES NO Was the child born prematurely?
If YES, Oxygen used? _____

YES NO Child trachea intubated at birth?
If YES, Any lasting effects? _____

YES NO Developmental Delays?

YES NO Asthma or Bronchitis?

YES NO Excessive Bleeding or Bruising, e.g. Nosebleeds, Cuts?

YES NO Muscular Problems?

YES NO Other significant Illnesses?

Who is your Child's Medical Doctor
or Pediatrician (Not Surgeon)? _____

I understand that my child is NOT to have anything to eat or drink as instructed prior or the day of surgery unless instructed otherwise by Anesthesia.

Signature of Parent or Legal Guardian