Maine Medical Partners Pediatric Surgery History Form

Last Name	First Name	MI	Date of Birth	Age
Person Completing Form	**Relationship to Child**	**Who Lives in Household with your child?**		
If school age, what grade is your child in?	**In Day Care? Yes No**	**Weight**	**Lbs**	**Kg**
Family Doctor / Pediatrician		**Consultant**		

MEDICAL HISTORY

Has your child ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided.

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Birth History			**Cardiac**			**Neurologic**			**Ear, Nose, & Throat**		
Term			High blood pressure			Seizures			Loose Teeth		
Prematurity			Murmur			VP Shunt			Nosebleeds		
If yes (wks)			Irregular heartbeat			Migraines			Deafness		
Birth weight:			Heart Defects			Hydrocephalus			Ear Infections		
Respiratory			**Gastrointestinal**			**Musculoskeletal**			Ear tubes		
Days on ventilator			Diarrhea			Muscle Disease			**Constitutional**		
Apnea/Bradycardia			Constipation			Arthritis			Fevers		
Asthma			Rectal bleeding			Scoliosis			Weight gain		
Pneumonia			Heartburn			Braces			Weight loss		
Cystic Fibrosis			Trouble swallowing			Fractures			Developmental Delay		
Croup			Hernia			**Skin**			ADD		
TB			Esophageal Reflux			Rash			Autism		
Tracheostomy			Jaundice / Liver Disease			Lumps / masses			**Blood Disorders**		
TEF			Hepatitis			Birthmarks			Easy Bruising / Bleeding		
Genetics			**Endocrine**			**Ophthalmic**			Anemia		
Trisomy 21			Diabetes			vision			Prior Transfusion		
Other			Thyroid Disorders			Strabismus			Leukemia / Lymphoma		

HISTORY **Please explain any YES answers in detailed description in box provided.**

Has your child ever had any surgery or been hospitalized? **Has your child had any problems with anesthesia? No ____ Yes _____ If yes, please list below:**	**O No** **O Yes**	**Surgical Operation**	**Date**	**Hospitalizations**	**Date**
Has your child ever used any tobacco or alcohol products?	**O No** **O Yes**				
Has your child ever used recreational /illicit drugs?	**O No** **O Yes**				

Is your child currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)? **Are your child's immunizations complete and up to date?** **Does your child have any allergies (including environmental, medications, food, and reaction to blood transfusion)?**	**O No** **O Yes** **O No** **O Yes** **O No** **O Yes**	**Medication**	**Dose**	**Times**	**Medication**	**Dose**	**Times**

FAMILY HISTORY*: Please indicate if your child's parents, brothers, or sisters have had any of the following conditions:*

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Birth Defects No ___ Yes __		Breathing Problems No ___ Yes_____		Heart Disease No ____ Yes ____	
Stomach/Intestine Problems No ___ Yes ___		Bleeding Problems No ___ Yes ___		Urinary/Kidney Problems No ___ Yes ___	
Problems with Anesthesia No ___ Yes ___		Other No ___ Yes ___		Cancer No ___ Yes ___	

_____ _____

Person Completing This Form / Relationship to Patient **Reviewed by Provider** **Date**