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**New Pediatric (ages 4-12) Health History (To be filled by the caregiver)**

* Completed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographics:**

* Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Is the child yours by:** a) Birth b) Adoption c) Stepchild d) Other

|  |  |
| --- | --- |
| **Past Medical History** | |
| Asthma |  |
| Eczema |  |
| Gastroesophageal reflux |  |
| Obstructive sleep apnea |  |
| Diabetes |  |
| Cancer (Specify) |  |
| Hypothyroidism |  |

**Other medical history**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bleeding tendency:**

* Are you on **blood thinners** (ex: Aspirin)?

1. No 2. Yes

**If Yes**, Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indications (why are you taking it):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Personal history** of bleeding tendency disease (ex. hemophilia, low platelets, leukemia)
* **Family history** of bleeding tendency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do your child take **Advil frequently**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past ENT surgical history:**

|  |  |
| --- | --- |
| **ENT surgeries** | **Date** |
| Sinus surgery |  |
| * *Septoplasty* (straightening of the septum) |  |
| * *Turbinoplasty* (reduction of turbinates due to swelling) |  |
| * *Endoscopic Sinus Surgery* (remove blockage/enlarge sinus openings) |  |
| * *Rhinoplasty* (plastic surgery of the nose) |  |
| *Tonsillectomy* (removal of tonsils) |  |
| *Adenoidectomy* (removal of adenoids) |  |
| *Ventilation tube* (Ear tubes) |  |
| Other ENT surgeries |  |

**Other surgical history and dates:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anesthesia:**

Any **family history** of anesthesia related problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child had history of surgery under general anesthesia. Has he/she had **any problems with anesthesia**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

* **Drug allergy**: Drug name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Latex Allergy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Mold exposure** at home or house? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications:** | | | |
| **Prescription Medications** | **Dosage** | **Frequency** | **Reason for taking** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Over the counter medications:** |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Vitamins** |  |  |  |
|  |  |  |  |
| **Herbal Supplement** |  |  |  |
|  |  |  |  |
| **See attached list** |  |  |  |

* Does the child complain of **snoring**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes or No

**If yes,** How many nights per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it loud snoring? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child stop breathing during sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is the child exposed to **second hand smoking**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does your child have **braces** or is going to receive one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does your child have **Attention Deficits Hyperactive Disease (ADHD)**: No or Yes

Suspected? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosed? Who diagnosed the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child under treatment? Yes (Behavioral or Medication) No

* Any concerns about **School performance**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you completing this health assessment☺**