MEDICAL HISTORY FOR PEDIATRICS

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Yrs. _____ Mos.

Height: ____ Feet _____ Inches Weight: _____ Lbs. Gender: [ ] Male [ ] Female

Current General Health Status: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Responsible Party: _____ Relationship to Patient: _____

Tel/Cell: _____ Email: _____

Mailing Address: _____

Dentist/Dental Office: _____ Phone: _____

Address: _____

Primary Physician: _____ Phone: _____

Address: _____

Specialist Physician: _____ Phone: _____

Address: _____

PREGNANCY/NEONATAL HISTORY:

1. Were there any complications during pregnancy or delivery? _____
   _____
2. Delivery: [ ] VAGINAL [ ] C-SECTION If C-Section, reason: _____
   _____
3. Was your child premature: [ ] NO [ ] YES, born at _____ weeks
4. Were there any complications during the newborn period? _____

8301 East Prentice Avenue, Suite 215
Greenwood Village, Colorado 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
www.carepointanesthesia.com

MEDICAL HISTORY FOR PEDIATRIC (Cont'd)

INFANCY/CHILDHOOD/ADOLESCENCE HISTORY:

1. Does your child have any allergies to drugs, supplements, or latex: [ ] NO [ ] YES

   Reactions: [ ] RASH [ ] HIVES [ ] EMERGENCY ROOM [ ] OTHER: _____

2. Has your child ever been hospitalized? [ ] NO [ ] YES (Explain): _____

3. Has your child ever had surgery? [ ] NO [ ] YES

   Type and Date of Surgery: _____

4. Has your child ever had general anesthesia? [ ] NO [ ] YES

   Any problems with anesthesia? _____

5. Has anyone in your family had problems with general anesthesia? [ ] NO [ ] YES

   What problems? _____

6. List all medications, drugs, and supplements your child is now taking: _____

   _____

7. Has your child ever been treated for, or diagnosed with any of the following conditions?

HEART DISEASES:	**NO**	**YES**	**WHEN**	**MEDICINE/TREATMENT**
Heart Murmur	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Irregular Heart Beat	_____	_____	_____	_____
Congenital Heart Defect	_____	_____	_____	_____
Other Heart Problem	_____	_____	_____	_____

LUNG DISEASES:	**NO**	**YES**	**WHEN**	**MEDICINE/TREATMENT**
Wheezing/Bronchiolitis	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Pneumonia	_____	_____	_____	_____
Obstructive Sleep Apnea	_____	_____	_____	_____
Other Lung Problem	_____	_____	_____	_____

OTHER CONDITIONS:	**NO**	**YES**	**WHEN**	**MEDICINE/TREATMENT**
Diabetes	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Seasonal Allergies/Eczema	_____	_____	_____	_____
GERD/Ulcer/Hernia	_____	_____	_____	_____
Recurrent Ear Infection	_____	_____	_____	_____
Seizure Disorder	_____	_____	_____	_____
Psychiatric Condition	_____	_____	_____	_____
Genetic Syndrome	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____
Anemia	_____	_____	_____	_____

8301 East Prentice Avenue, Suite 215
Greenwood Village, Colorado 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
www.carepointanesthesia.com

MEDICAL HISTORY FOR PEDIATRIC (Cont'd)

8. Please list any other medical conditions: _____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my child's treatment and treatment results. I also certify that CarePoint may communicate patient information using the contact information listed above.

Parent/Legal Guardian Signature: _____ Date: _____

8301 East Prentice Avenue, Suite 215
Greenwood Village, Colorado 80111-2990
Tel: 720-606-4220 ; Fax: 720-606-4221
Email: info@carepointanesthesia.com
www.carepointanesthesia.com