

PEDIATRIC SURGICAL ASSOCIATES
MEDICAL HISTORY FORM

Male Female

PRINT PLEASE!

GENERAL INFORMATION

TODAY'S DATE _____

PATIENTS NAME _____ DATE OF BIRTH _____

REASON FOR VISIT _____

CHILD'S PERSONAL PHYSICIAN _____ MEDICATION ALLERGIES _____

CURRENT MEDICATIONS (dose/frequency) _____

IMMUNIZATIONS UP TO DATE? (Y/N) _____ CURRENT WEIGHT _____ lbs.

DIET (Formula, breast milk, table food, etc.) _____

BIRTH HISTORY

BIRTH WEIGHT _____ TERM _____ PREMATURE _____ (NUMBER WEEKS GESTATION _____)

DELIVERY: VAGINAL ____ C-SECTION ____ BIRTH COMPLICATIONS? (Y/N) ____ IF YES, DESCRIBE ____

MEDICAL HISTORY

GROWTH AND DEVELOPMENT: NORMAL ____ DELAYED ____, EXPLAIN: _____

PRIOR SERIOUS ILLNESS? (Y/N) ____ IF YES, DATE AND NATURE OF ILLNESS _____

PRIOR HOSPITALIZATIONS? (Y/N) ____ IF YES, GIVE HOSPITAL, DATE AND REASON FOR ADMISSION ____

ACCIDENTS/INJURIES REQUIRING HOSPITALIZATION? (Y/N) ____ IF YES, GIVE HOSPITAL, DATE AND NATURE OF INJURY (IES) _____

SURGICAL HISTORY

PRIOR SURGERIES? (Y/N) ____ IF YES, GIVE HOSPITAL, DATE AND TYPE OF SURGERY PERFORMED ____

PRIOR ANESTHETIC COMPLICATIONS? (Y/N) ____ IF YES, DESCRIBE _____

FAMILY HISTORY

DOES/HAS ANYONE IN THE FAMILY HAVE/HAD PROBLEMS WITH ANY OF THE FOLLOWING?:

BLEEDING TENDENCIES? (Y/N) _____ ANESTHETIC COMPLICATIONS? (Y/N) _____

MUSCULAR DYSTROPHY? (Y/N) _____ GENETIC OR BIRTH DEFECTS? (Y/N) _____

SOCIAL HISTORY

CITY OF RESIDENCE _____ DOES PATIENT LIVE WITH: BIOLOGICAL MOTHER? __

BIOLOGICAL FATHER? __ BOTH? __ GUARDIAN? __ RELATIVE? __ ADOPTIVE PARENTS? __ OTHER? __

OTHERS LIVING IN RESIDENCE _____

PATIENT'S PRESENT GRADE IN SCHOOL _____

GO TO OTHER SIDE

REVIEWED AND UPDATED

DATE _____

M.D. _____

HAS YOUR CHILD HAD PROBLEMS WITH ANY OF THE FOLLOWING?

SEIZURES: YES ____ NO ____ HEART DISEASE: YES ____ NO ____ URINARY TRACT/
 BLADDER INFECTIONS: YES ____ NO ____

VISION: YES ____ NO ____ LUNG DISEASE: YES ____ NO ____ BONE/JOINT DISEASE: YES ____ NO ____

HEARING: YES ____ NO ____ KIDNEY DISEASE: YES ____ NO ____ DIGESTIVE TRACT: YES ____ NO ____

BLEEDING: YES ____ NO ____ BREATHING: YES ____ NO ____ SICKLE CELL DISEASE: YES ____ NO ____

ANEMIA: YES ____ NO ____ PNEUMONIA: YES ____ NO ____ LIVER DISEASE: YES ____ NO ____

OTHER: _____

STOP!

REVIEWED AND UPDATED
 DATE _____
 M.D. _____

OFFICE USE ONLY!

PHYSICAL EXAM

VITAL SIGNS: PULSE _____ BP _____ RR _____

GENERAL: WD, WN, NONTOXIC, ALERT, ORIENTED

SKIN: WELL HYDRATED, MOIST MUCOSA, GOOD TURGO
 NO RASH
 NO SIGNIFICANT LESIONS

HEENT: NORMOCEPHALIC, ATRAUMATIC OR SOFT AF
 EOMI, PERRL, ANICTERIC SCLERAE
 NARES PATENT
 OROPHARYNX CLEAR
 NO DYSMORPHIC FEATURES

NECK/BACK: SUPPLE, FROM, NO MASSES
 NORMAL ALIGNMENT

CHEST: SYMMETRICAL, NORMAL CONTOUR

LUNGS: UNOBSTRUCTED UPPER AIRWAY SOUNDS
 BREATH SOUNDS EQUAL/CLEAR BILATERALLY

HEART: REGULAR RATE, NO MURMURS

ABDOMEN: NORMOACTIVE BOWEL SOUNDS
 SOFT, NONTENDER, NO MASSES/ORGANOMEGALY

GENTALIA:

MALE: NORMAL PENIS: *CIRCUMCISED?* YES NO
 FULLY DESCENDED TESTES

FEMALE: NORMAL EXTERNAL EXAM

ANUS: PATENT
 NORMAL LOCATION

EXTREMITIES: FROM, WITHOUT CYANOSIS, CLUBBING, EDEMA
 NO LESIONS

NEUROLOGIC: MOVES ALL EXTREMITIES, NO FOCAL FINDINGS

IMPRESSION:

PLAN:

Physician's Signature _____

REVIEWED AND UPDATED
 DATE _____
 M.D. _____