Pediatric Health History Form

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Name: ____________ Date of Birth: ____________ Height: ______ Weight: ______

Address: ____________ City: ____________ State: ______ ZIP: ______

Cell: ____________ Home: ____________ Gender: ______

Treating Dentist: ____________ Email: ____________

Does your child have any ALLERGIES (include foods)? ____________

What MEDICATIONS does your child take? ____________

List your child's Pediatrician name and number as well as any specialists (REQUIRED) ____________

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List all previous/upcoming surgeries or hospitalizations. ____________

Check ALL that apply **YES** **NO**

1) Was your child born prematurely? How many weeks? ____________
2) Does your child have history of: congenital heart disease/defects, heart murmur, heart attack, palpitations, arrhythmia, cardiac arrest? ____________
3) Does your child have asthma, reactive airway disease, frequent respiratory infections, or pneumonia?
   Rate asthma: mild, moderate or severe? Has your child been hospitalized for asthma? ____________
   Does your child use a maintenance inhaler? ______ Does your child use albuterol? ____________
   How often does your child use their albuterol inhaler? ____________
   Is the asthma well controlled? ____________
4) Does your child have any other respiratory problems like cystic fibrosis or bronchitis? ____________
5) Does your child snore loudly at night or have obstructive sleep apnea? Sleep study? ____________
6) Does your child have enlarged tonsils or adenoids? Have their tonsils and adenoids been removed or recommended to be removed? ____________
7) Does your child have any syndromes, cerebral palsy, genetic disorders, special needs? ____________
8) Does your child have any endocrine abnormalities like thyroid problems or diabetes? ____________
9) Does your child have a seizure disorder or other neurological diseases/abnormalities? ____________
10) Does your child have a history of frequent nosebleeds? ____________
11) Does your child have any liver problems or bleeding or clotting disorders? ____________
12) Does your child have any kidney problems or renal diseases? ____________
13) Does your child have muscular dystrophy, low muscle tone, rhabdomyolysis or other muscular problems?
14) Does your child have a history of cyanosis, hypertension or chest pain on exertion? ____________
15) Does your child have cancer, anemia, sickle cell disease or sickle cell trait? ____________
16) Does your child have an infectious disease? ____________
17) Has your child had recent respiratory infection/illness, Flu, RSV, COVID? ____________
    Was any therapy/hospitalization required, such as breathing treatment? ____________
18) **Does your child or blood relative have history of Malignant Hyperthermia or pseudocholinesterase deficiency? Any other personal or family history of problems with anesthesia?** ____________
19) Does your child have autism, ADHD/ADD, anxiety, depression, or other mental/behavioral health concerns?
20) Please list and describe any other health issues or concerns not covered above. ____________

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I have reviewed the above medical health history completely and have answered all questions truthfully and to the best of my knowledge. I understand withholding information about my health could pose risks to my safety. I hereby give permission to Luxe Anesthesia Services to discuss my medical health with other health professionals and consent to the release of medical records for the purpose of obtaining medical consultations.

Patient Name: ____________ Signature: ____________ Date: ____________