Patient # ____________________ **Today's Date** ______________________

Pediatric, Adolescent Surgical Associates, P.C.

Suite 570 5455 Meridian Mark Road Atlanta, GA 30342 (404) 252-3353 Fax (404) 252-0645

CHILD's Legal Name ____
First Middle Last

Age __________ Date of Birth ______________ Birth Weight ______________ Nickname ______________
Pounds Ounces

Sex __________ Current Height ______________ Current Weight ______________
Feet Inches Pounds Ounces

Who referred you here today? ____

Who is your child's pediatrician? (if different from above) ______________________________

Why are you here today? ____

____

When did problem begin? ____

The CHILD'S general health is: ❑ GOOD ❑ FAIR ❑ POOR

Are the CHILD'S immunizations up to date? ❑ YES ❑ NO
If NO, please specify: ____

Medications

List all medications your CHILD is currently taking: ______________________________

____

List all vitamins, supplements, herbs your CHILD is currently taking: ______________________

List all medications your CHILD is ALLERGIC to: ______________________________

Past Medical History

List all surgeries your child has had, when, and where: ______________________________

____

____

List all hospitalizations other than for surgery indicating why, when, and where: ______________

____

Family History

Please check the appropriate box if any of the following disorders are found in your family:

- ❑ Bleeding Problems/Prolonged Bleeding
- ❑ Problems with Anesthesia/Sedation
- ❑ Cancer
- ❑ Genetic Disorders/Syndromes
- ❑ Sickle cell anemia or sickle cell trait
- ❑ Other

Please specify if any of the above are checked: ______________________________

____

List siblings and ages ____

Is there a smoker living in the home of the child? ❑ YES ❑ NO

Are there any pets living in the home of the child? ❑ YES ❑ NO If yes, please list: ______________

Does your home utilize: ❑ city water ❑ well water?

______________________________ M.D.

PLEASE COMPLETE NEXT PAGE

Review of Systems **Child's Name** ______________________________

Please check the appropriate box if your child has any of the following:

Birth History

- ❑ Prematurity: weeks gestation_____ OR weeks early _______
- ❑ C-section
- ❑ Apnea Monitor
- ❑ Other ______________________________

Heart or Blood Problems ❑ YES ❑ NO

- ❑ Heart Defect
- ❑ Bleeding Problems
- ❑ Sickle Cell Disease/Trait
- ❑ HIV Positive
- ❑ Other ______________________________

Lung or Breathing Problems ❑ YES ❑ NO

- ❑ Asthma/Wheezing
- ❑ Croup
- ❑ Chronic Bronchitis
- ❑ Cystic Fibrosis
- ❑ Other ______________________________

Digestive System Problems ❑ YES ❑ NO

- ❑ Hepatitis
- ❑ Intestines/Bowels
- ❑ Liver
- ❑ Gastro-esophageal Reflux
- ❑ Stomach
- ❑ Other ______________________________

Nervous System Problems ❑ YES ❑ NO

- ❑ Convulsions, Seizures, or Fits
- ❑ Cerebral Palsy
- ❑ Hydrocephalus
- ❑ Down's Syndrome
- ❑ Myelomeningocele
- ❑ Developmental Delay
- ❑ Learning Disability
- ❑ Other ______________________________

Muscle or Bone/Joint Problems ❑ YES ❑ NO

- ❑ Muscle Disorder
- ❑ Bone Disease
- ❑ Joint Disease
- ❑ Rheumatoid Arthritis
- ❑ Other ______________________________

Kidney or Bladder Problems ❑ YES ❑ NO

- ❑ Explain ______________________________

Glandular Problems ❑ YES ❑ NO

- ❑ Diabetes
- ❑ Thyroid
- ❑ Other ______________________________

Has Menstruation Started? ❑ YES ❑ NO

Date of Last Menstrual Period ____________________

Cancer/Chemotherapy ❑ YES ❑ NO

If Yes, please explain ______________________________

Other Problems or Syndromes ❑ YES ❑ NO

If Yes, please explain: ______________________________

____

______________________________ M. D.