

Rocky Mountain Pediatric Surgery Patient Registration

General Information

Patient Name _____

Reason for Visit _____

Pediatrician of Family Doctor _____

How much does your child weigh currently? _____

Birth History

How much did you child weigh at birth? _____ pounds _____ ounces

If you child was born early (premature), how many weeks? _____ weeks

Was the child born vaginally or by C-section? Vaginally C-Section

Was the child jaundiced (yellow) as a newborn? Yes No

Did the child require oxygen or a ventilator in the nursery? Oxygen Ventilation None

How old was the child at discharge from the hospital? _____ (Age)

Medical History

Please list any hospitalizations None

Age _____ Reason for Hospitalization _____

Age _____ Reason for Hospitalization _____

Age _____ Reason for Hospitalization _____

Age _____ Reason for Hospitalization _____

Surgical History

Please list any operations (and approximate age). Please tell us if there were anesthetic problems.

Age _____ Operation _____

Age _____ Operation _____

Age _____ Operation _____

Age _____ Operation _____

Rocky Mountain Pediatric Surgery Patient Registration

Anesthetic problems? _____

Allergies

Please list all known allergies

Medications _____ Reaction _____

Medications _____ Reaction _____

Medications _____ Reaction _____

Foods _____ Reaction _____

Foods _____ Reaction _____

Other _____ Reaction _____

Latex Yes No

Current Medications

Please list all medications your child takes now.

Medication _____ Dose and frequency _____

Medication _____ Dose and frequency _____

Medication _____ Dose and frequency _____

Medication _____ Dose and frequency _____

Health Problems

Please check any of the following that apply to your child. None

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Croup | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> RSV/Bronchiolitis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Frequent Constipation | <input type="checkbox"/> Reflux Disease |

Rocky Mountain Pediatric Surgery Patient Registration

Immunizations

- Are all immunizations up to date? Yes No
- Has your child had Chicken Pox? Yes No
- Has your child had the Chicken Pox vaccine? Yes No

Bleeding Problems

- Does your child have hemophilia or von Willebrand's Disease? Yes No
- Does your child bruise easily? Yes No
- Does your child have chronic nose bleeds or bleeding gums? Yes No
- Is there any family history of bleeding disorders? Yes No
- If yes who? _____ Relation _____

Adolescent History

- What age did menstruation begin? _____ Date of last period _____
- Are periods regular? Yes No
- Does the child smoke? Yes No

Family History

Please list ages of siblings and parents and describe medication allergies, problems with anesthesia, and chronic illnesses. (like asthma, diabetes, etc)

Mother name _____ Age _____ Health information _____

Father name _____ Age _____ Health information _____

Sibling name _____ Age _____ Health information _____

Sibling name _____ Age _____ Health information _____

Sibling name _____ Age _____ Health information _____

- Has anyone in the family had an abnormal reaction to general anesthesia? Yes No

Rocky Mountain Pediatric Surgery
Patient Registration

Is there anything else you want us to know about you child?

Please describe any other concerns you want us to address or things you think we should know to protect you child during their clinic visit, operation, or hospitalization.

Signature _____ Date _____