MID COAST HOSPITAL

AMBULATORY CARE/SURGICAL SERVICES
NURSING HISTORY FOR PEDIATRICS

Form to be filled out by parent or legal guardian

NAME: _____ **DATE OF BIRTH:** _____

SURGEON: _____ **PRIMARY CARE PHYSICIAN:** _____

SCHEDULED SURGERY OR PROCEDURE: _____

REASON FOR PROCEDURE: _____

HEIGHT: _____ **WEIGHT:** _____

Source of Information: _____ **Name/Relationship:** _____ **Phone:** _____

Contact in case of emergency (if different than above) _____ **Phone:** _____

Whom does the child live with (parent(s), siblings, grandparent)? _____

Legal Custody/Guardian _____ **Phone:** _____

SURGICAL HISTORY

Type of Surgery	Date

PAST MEDICAL HOSPITAL ADMISSIONS (NONSURGICAL)

Admission Reason	Date

Has your child had any anesthesia complications? ☐ Yes ☐ No ☐ Not Applicable

If Yes, please explain: _____

Has anyone in your family had anesthesia complications? ☐ Yes ☐ No

If Yes, please explain: _____

Has your child had any surgical complications? ☐ Yes ☐ No ☐ Not Applicable

If Yes, please explain: _____

DRUG ALLERGIES (LIST REACTION)	LIST FOOD ALLERGIES	ENVIRONMENTAL ALLERGIES
		LATEX ALLERGY? ☐ **Yes** ☐ **No**

(PLEASE CHECK ALL THAT APPLY, as appropriate per age)
DOES YOUR CHILD HAVE DIFFICULTY WITH?

☐ Mobility _____
☐ Swallowing _____
☐ Speaking _____
☐ Reading _____
☐ Vision _____
☐ Hearing/Language/Communication
Primary spoken language: _____
Do you want an interpreter provided?
☐ Yes ☐ No ☐ Not necessary
If one is needed and declined, who will be the interpreter? _____

Do you have Home Health Services? ☐ Yes ☐ No
If Yes, name of agency: _____
_____

DOES YOUR CHILD USE OR HAVE?

☐ Hardware/Implants/Braces
Please list: _____
_____
_____
_____

☐ Prosthetics; such as artificial limbs, eyes

PKTMCH-00113 (3/13)

(PLEASE COMPLETE REVERSE SIDE OF FORM)

DEVELOPMENT ASSESSMENT

Was your child full term at birth? ☐ Yes ☐ No
If No, then any current or potential problems as a result? _____
Is your child's growth and development normal per age? ☐ Yes ☐ No
If No, Please describe the delay: _____
Any behavioral problems? ☐ Yes ☐ No
If yes, please explain: _____
Is your child currently enrolled in day care or school? ☐ Yes ☐ No
Does your child have any identified learning needs we should know about? ☐ Yes ☐ No (define) _____
Is your child toilet trained? ☐ Yes ☐ No

NUTRITION

Does your child eat a regular diet?	☐ Yes	☐ No
Have a good appetite?	☐ Yes	☐ No
Have an eating disorder?	☐ Yes	☐ No
Have any loose teeth?	☐ Yes	☐ No

MEDICAL HISTORY

HAS YOUR CHILD EVER HAD OR IS CURRENTLY EXPERIENCING ANY OF THE FOLLOWING: (PLEASE CHECK ALL THAT APPLY)

☐ Heart/Valve problems _____
☐ Bleeding disorders/Anemia _____
☐ Breathing/Lung problems _____
☐ **Recent** cold/FLU/Infection _____
☐ Diabetes _____
☐ Liver problems _____
☐ Thyroid problems _____
☐ Diarrhea/Constipation/Bowel problems _____
☐ Reflux/Stomach problems _____
☐ Migraines/Headaches _____
☐ Seizures/Convulsions _____
☐ Muscle problems/Paralysis _____
☐ Arthritis _____
☐ Difficulty opening jaw/TMJ _____
☐ Kidney problems/Urinary tract infections _____
☐ Cancer (where?) _____

☐ Skin problems _____
☐ MRSA infection _____
☐ Depression/Anxiety disorder/ADD/ADHD _____
☐ Recreational drug use _____
☐ Tobacco use _____

OTHER MEDICAL PROBLEMS ☐ Yes ☐ No
Is there anything else you would like to discuss?
☐ Yes ☐ No _____

FEMALES (If age appropriate please fill out)
Has your daughter started her menses?
☐ Yes ☐ No
What is the date of her last menstrual period? _____

IMMUNIZATIONS:
Are they up to date? ☐ Yes ☐ No
If no, then please explain: _____

Has there been any recent patient or family exposure to contagious diseases? (Chicken pox, measles, mumps, rubella, RSV, TB, pertussis, parasites or other)? ☐ Yes ☐ No (If yes, please explain) _____

Is your child currently experiencing or do they have a past history of abuse or neglect? ☐ Yes ☐ No
Do you have any religious or cultural beliefs that will affect the care we provide? ☐ Yes ☐ No

Please provide the number where you can be reached on the **morning of your procedure:** (____) _____
How long will it take for you to get to the hospital? _____

Filled out by Parent or Legal guardian: _____ **(name)**

Reviewed by: _____ _____
(Signature of **PAT Nurse**) (Date/Time)

_____ _____
(Signature of **Preop/Admission Nurse**) (Date/Time)

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MEDICATION HISTORY

Please complete the following section OR bring your personal medication card with you:

Include prescription medications, over the counter medications, herbal supplements, and vitamins.

Drug	**Dose**	**How often taken?**	**Route** (by mouth, inhaler, injection etc.)

Form Completed by: ☐ Patient ☐ Other (name) _____