AtlantiCare SURGERY CENTER

2500 English Creek Road, Bldg. 700, Suite 702
Egg Harbor Township, NJ 08234
Fax # (609) 645-2023

PEDIATRIC PATIENT HEALTH QUESTIONNAIRE

*Please complete this Questionaire and **fax or mail** it to the above address as soon as possible.*
Call 407-2551 or 407-2552 if you have any questions.

Child's Name:_____ Parent's Name: _____

Address:_____ City: _____State:_____Zip:_____

Telephone: Home (____) _____ Work (____) _____

Cell Phone: (____) _____ E-Mail _____

Surgeon: John Tung _____ Primary Care Physician: _____

Procedure: _____ Date of Surgery: _____

Age (in Years): _____ Date of Birth: _____ Sex: □ Male □ Female Height (Feet/Inches): _____ Weight (Lbs): _____

List all medications your child takes: _____

List all current allergies, including medications, latex, food, or intravenous contrast agents: _____

List all operations your child has had:

Recent Hospitalizations/Treatments:

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

ANESTHESIA

Anesthesia	**Yes □ No □**	Problem with anesthesia	**Yes □ No □**
History of sleep apnea	**Yes □ No □**	*If yes*, has child ever been on an apnea monitor	**Yes □ No □**
Hiatal hernia or acid reflux	**Yes □ No □**	Family member ever had a problem with anesthesia	**Yes □ No □**

CARDIAC

Heart condition	**Yes □ No □**	*If yes*, when Date: _____	
Narrowed or leaking heart valve	**Yes □ No □**	Rapid heart rate or irregular heartbeat	**Yes □ No □**
Heart murmur	**Yes □ No □**	*If yes*, was he/she seen by a cardiologist	**Yes □ No □**

RESPIRATORY

Short of breath easily	**Yes □ No □**	A cold in the last two weeks	**Yes □ No □**
Asthma or wheezing	**Yes □ No □**	*If yes*, last episode Date:_____	

ENDOCRINE

Diabetes **Yes □ No □** Kidney disease **Yes □ No □**

NEUROLOGIC

Seizures or episodes of unconsciousness **Yes □ No □**

Cerebral palsy **Yes □ No □** • Developmentally delayed **Yes □ No □** Bleeding problems **Yes □ No □** • Anemia **Yes □ No □**

Hepatitis **Yes □ No □** *If yes,* when Date: _____ Chipped, loose teeth, caps or braces **Yes □ No □**

Premature birth **Yes □ No □** Birth weight_____ *If yes,* by how many weeks? _____

How long was your child in the hospital after delivery _____ Admitted to a hospital since delivery **Yes □ No □**

Are immunizations current **Yes □ No □**

Anything else you would like us to know about your child? *If yes*, please explain:

I_____ ☐ parent or ☐guardian, verify that the information I provided in _____(patient's name) health history questionnaire is a complete and accurate description of his/her medical/surgical history, including medication use. I understand that his/her treating providers need this information to plan his/her anesthesia and surgical care while in the Surgery Center and failure to accurately disclose this information could result in serious consequences to his/her health.

Signature_____ Date_____