

**VALLEY AMBULATORY SURGERY CENTER
ST CHARLES, IL
630-584-9800 - FAX 630-584-9902
PEDIATRIC PATIENT HISTORY FORM**

PATIENT NAME	SURGEON
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DATE OF SERVICE

PLEASE COMPLETE, RETURN IN THE ENCLOSED ENVELOPE/OR FAX TO 630-584-9902 AND BRING ORIGINAL WITH YOU THE DAY OF SURGERY

HAVE YOU HAD OR DO YOU STILL HAVE ANY OF THE FOLLOWING:

HEIGHT								
WEIGHT								
	Y	N		Y	N		Y	N
Allergies to medications			Any prior surgeries?					
Any other allergies								
A cold in past 2 weeks			Any prior surgeries at VASC?					
Shortness of breath								
Asthma			Have you or your family had an					
Pneumonia			unusual reaction to anesthesia?					
Other respiratory difficulty			Malignant hyperthermia?					
Rheumatic fever			Have you or your family had any					
Palpitations, irregular/ fast heart beat			bleeding problems?					
Jaundice, Hepatitis			Any other medical conditions?					
Infectious Mononucleosis								
Convulsions, epilepsy								
Polio, paralysis, meningitis								
Diabetes								
Kidney trouble								

ANY MEDICATION ALLERGIES	YES	NO	CURRENT MEDICATIONS	DOSAGE/FREQUENCY
Please List.				
ANY OTHER ALLERGIES	YES	NO		
LATEX ALLERGIES	YES	NO		
PREVIOUS SURGERIES			Herbal remedies	
			Steroids in last 6 mo.	
			Over the counter medications	

I HAVE RECEIVED THE PATIENT INFORMATION/ BILL OF RIGHTS SHEET BEFORE THE DAY OF SURGERY	Y	N
	<input type="checkbox"/>	<input type="checkbox"/>

NURSES NOTES/COMMENTS

PEDIATRICIAN NAME/PHONE NUMBER

REVIEWED WITH PATIENT _____ RN _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PLEASE FILL IN ENTIRE FORM AND SIGN BEFORE SUBMITTING