Mankato Clinic

Health History – Pre-Op

Brought into clinic by _____

Past Health History

A. Medical History

1. Has your child had an allergic reaction to:
   - ☐ Medications _____
   - ☐ Foods _____
   - ☐ Inset bites _____
   - ☐ Trees, molds, dust, etc. _____
   - ☐ Animals _____
   - ☐ Tape _____
   - ☐ Latex _____
   - ☐ Other _____

2. Has your child had reactions to any immunizations? Yes / No Which ones? _____

3. Has your child had (please check):
   - ☐ Hospitalization(s)
   - ☐ Surgery (ies)
   - ☐ Serious injuries/accidents
   - ☐ Broken bones or stitches
   - ☐ Fainting episodes
   - ☐ Head injuries
   - ☐ Loss of consciousness
   - ☐ Concussion
   - ☐ Sports injury (ies)
   - ☐ Meningitis
   - ☐ Chicken pox
   - ☐ Pneumonia
   - ☐ Migraine headaches
   - ☐ Frequent respiratory infections
   - ☐ Sinus infections
   - ☐ Diabetes
   - ☐ Seizures
   - ☐ Ear infections
   - ☐ Hay fever / Allergies
   - ☐ Anemia (low iron in blood)
   - ☐ Asthma
   - ☐ Strep infections / Scarlet fever
   - ☐ Measles
   - ☐ Bladder / Kidney infection
   - ☐ Mononucleosis
   - ☐ Blood clots
   - ☐ Hepatitis
   - ☐ Depression
   - ☐ ADD / ADHD
   - ☐ Eating disorder – bulimia or anorexia
   - ☐ Liver problems
   - ☐ Blood transfusion
   - ☐ Bleeding problems
   - ☐ HIV (AIDS)

4. Has your child had anesthesia before? Yes / No

5. Has your child had any reactions to anesthesia? Yes / No

6. Has your child ever required any special tests? Yes / No Please describe _____

7. Please list any information about your child that you feel we should know _____
   _____

B. Current Health History

1. Please list any medications taken on a regular basis _____

2. Has your child had all his/her immunizations (shots)? Yes / No / Not Sure

C. Family History

☐ My child is adopted – family history is unknown ☐ My parent is adopted – family history is unknown

1. Check any diseases that **your child's parents, grandparents, brothers, sisters, aunts or uncles** have had:

☐ Eczema / Psoriasis
☐ Migraine headaches
☐ Sinus problems
☐ Vision problems / crossed eyes
- Glaucoma
- Cataracts

☐ Hearing problems / Deafness
☐ Ear infections
☐ Allergy / Hayfever
☐ Thyroid problems
☐ Asthma
☐ Tuberculosis
☐ Heart problems / heart attacks
☐ Heart murmur
☐ Stroke
☐ Blood clots
☐ High blood pressure
☐ High cholesterol
☐ Sudden deaths during exercise
☐ Ulcers
☐ Gallbladder disease
☐ Liver problems
☐ Kidney problems / Bladder infections
☐ Diabetes
☐ Anesthesia **reactions**
☐ Cancer
☐ Bleeding **disorders**
☐ Sickle cell disease
☐ Epilepsy / Seizures
☐ Obesity (overweight)
☐ Mental health problems
☐ Depression / Schizophrenia / Bipolar
☐ Alcohol or Drug problems

List any other illnesses that run in your family _____

D. Review of Systems

1. Please check if your child has any of the following:

☐ Rashes
☐ Bruises easily
☐ Birthmarks / Moles
☐ Headaches
☐ Dizziness
☐ Mattery eyes
☐ Loss of eyesight
☐ Pain in ears
☐ Drainage from ears
☐ Difficulty hearing
☐ Ringing in ears
☐ Hearing loss
☐ Frequent runny nose / stuffy nose
☐ Frequent bloody nose
☐ Frequent sore throat
☐ Hoarse sounding voice
☐ Difficulty swallowing
☐ Difficulty breathing
☐ Wheeze/cough during or after exercise
☐ Frequent cough
☐ Heart murmur
☐ High blood pressure
☐ Poor activity level / get tired easily
☐ Nausea
☐ Vomiting
☐ Stomach cramps / pain
☐ Joint pain / Stiffness / Swelling

2. Has your child used **aspirin** within seven (7) days of surgery? Yes / No

Reviewed by _____