

Ambulatory Surgery Center of Western New York  
3112 Sheridan Drive, Amherst, New York 14226

**PEDIATRIC HEALTH HISTORY**

FORM TO BE COMPLETED BY PATIENT'S PARENT/GUARDIAN

PATIENT NAME: \_\_\_\_\_

PARENT/GUARDIAN NAME : \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

PHONE NUMBER OF PRIMARY CARE PHYSICIAN: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

SCHEDULED PROCEDURE:				
BLOOD PRESSURE	TEMP	PULSE	RESP	SaO2 on room air
1. CONSENT FORM SIGNED/DATED/WITNESSED <input type="checkbox"/> 2. NPO <input type="checkbox"/> 3. PATIENT TEACHING COMPLETED <input type="checkbox"/> 4. I.D. BAND <input type="checkbox"/> DOB <input type="checkbox"/> PROCEDURE REVIEWED WITH PATIENT/GUARDIAN <input type="checkbox"/>				NURSES NOTES: _____ _____ _____
	YES	NO	DESCRIPTION	
CONTACT LENSES				
DENTURES				
HEARING AID				
NURSING DIAGNOSIS: Potential for anxiety, patient knowledge deficit. GOAL: Decrease patient anxiety through education				
Skin Condition:			LOC:	
<input type="checkbox"/> intact <input type="checkbox"/> pale <input type="checkbox"/> warm <input type="checkbox"/> flushed <input type="checkbox"/> diaphoretic <input type="checkbox"/> cool			<input type="checkbox"/> alert <input type="checkbox"/> sedated <input type="checkbox"/> agitated <input type="checkbox"/> confused <input type="checkbox"/> oriented <input type="checkbox"/> anxious <input type="checkbox"/> unresponsive	
TRANSPORTED TO OR VIA: AMBULATORY WITH ASSIST <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> STRETCHER <input type="checkbox"/>				
NURSES SIGNATURE: _____				

