Banner Health®

NEW PATIENT MEDICAL HISTORY
PEDIATRIC PLASTIC SURGERY

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Person filling out form and relationship to patient: _____

Parent Occupation: _____

How did you hear about us? _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Reason for visit: _____

ALLERGIES

❑ **No known allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

❑ **No Medications** List any medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**	**Date medication started:**

❑ Immunization History Unknown ❑ Immunization up-to-date ❑ No immunizations by choice

PATIENT MEDICAL HISTORY

List any current or past medical conditions (please place checkmark by any current problems).

❑ _____

❑ _____

❑ _____

❑ _____

❑ _____

Banner Health®

NEW PATIENT MEDICAL HISTORY
PEDIATRIC PLASTIC SURGERY

SURGERIES AND/OR HOSPITALIZATIONS

Has your child had any surgeries or has been hospitalized? (provide dates and reason below)

Date:	Reason:	Date:	Reason:

FAMILY HISTORY

List health conditions for each family member. **Please include easy bruising/bleeding, blood clots, reaction to anesthesia, birth defects, and miscarriage/pregnancy loss.**

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Brother				
Sister				

SOCIAL HISTORY

Does anyone in the home smoke? ❑ Yes ❑ No If yes, do they smoke outside only? ❑ Yes ❑ No

Is your child ❑ Breastfeed ❑ Formula ❑ N/A Frequency/duration of feeding: _____ Amount: _____

Patient lives with: ❑ Mother ❑ Father ❑ Siblings ❑ Grandparents ❑ Step-Parents ❑ Foster Parents ❑ Adoptive Parents

Extracurricular activities/sports: _____

Child attends school: _____ Grade: _____ ❑ Not applicable

Special therapies/education? ❑ Yes ❑ No If yes, explain: _____

Are there pets in the home? ❑ Yes ❑ No If yes, list: _____

Which hand is your child's dominant hand? ❑ Right hand ❑ Left hand ❑ Ambidextrous ❑ Undetermined

BIRTH HISTORY

Patient Adopted _____ If yes, Birth Country: _____

Birth Hospital: _____

Birth Weight: _____lbs. _____oz. Length: _____ Head Circumference: _____ inches Time of Birth: _____

Type of delivery: ❑ Normal Vaginal ❑ C-Section ❑ Repeat C-Section ❑ Emergent C-Section (Reason) _____

Complications during pregnancy/delivery: _____

Gestational age at birth: _____ weeks

Were any medications, herbs, alcohol, or drugs used during pregnancy? ❑ Yes ❑ No If yes, explain: _____

_____

5100-0029
(10/2015)

Banner Health®

NEW PATIENT MEDICAL HISTORY
PEDIATRIC PLASTIC SURGERY

REVIEW OF SYSTEMS

CONSTITUTIONAL			CARDIOVASCULAR			ENDOCRINE		
Chills	Yes	No	Abnormal blood pressure	Yes	No	Excessive thirst	Yes	No
Decreased activity	Yes	No	Chest pain	Yes	No	Excessive urination	Yes	No
Decreased appetite	Yes	No	Fainting	Yes	No	**MUSCULOSKELETAL**		
Fatigue	Yes	No	Irregular heart beat	Yes	No	Bone pain	Yes	No
Fever	Yes	No	Murmur	Yes	No	Joint pain	Yes	No
Fussiness	Yes	No	**GASTROINTESTINAL**			Joint swelling	Yes	No
Irritability	Yes	No	Abdominal pain	Yes	No	Muscle pain	Yes	No
Lethargy	Yes	No	Constipation	Yes	No	Muscle weakness	Yes	No
Weight gain	Yes	No	Diarrhea	Yes	No	**SKIN**		
Weight loss	Yes	No	Reflux	Yes	No	Acne	Yes	No
EENMT			Vomiting	Yes	No	Itching	Yes	No
Difficulty swallowing	Yes	No	**GENITOURINARY**			Rash	Yes	No
Dry mouth	Yes	No	Blood in urine	Yes	No	Skin lesion	Yes	No
Ear discharge/drainage	Yes	No	Decrease in urine output	Yes	No	**VASCULAR**		
Esotropia (cross eyed)	Yes	No	Enuresis (bedwetting)	Yes	No	Cool extremities	Yes	No
Eye redness	Yes	No	Flank pain	Yes	No	Cyanosis (blue/purple skin)	Yes	No
Headaches	Yes	No	Foul urine odor	Yes	No	Edema (swelling)	Yes	No
Hearing loss	Yes	No	Painful urination	Yes	No	**PSYCHIATRIC**		
Nasal congestion	Yes	No	**REPRODUCTIVE (MALE)**			Behavioral changes	Yes	No
Otalgia (ear aches)	Yes	No	Circumcised	Yes	No	Difficulty concentrating	Yes	No
Pharyngitis (sore throat)	Yes	No	Penile discharge	Yes	No	Distorted body image	Yes	No
Rhinorrhea (runny nose)	Yes	No	Scrotum/testicular mass	Yes	No	Inappropriate interaction	Yes	No
Sneezing	Yes	No	Scrotum/testicular pain	Yes	No	Inconsolable	Yes	No
Tearing	Yes	No	**REPRODUCTIVE (FEMALE)**			Self-conscious	Yes	No
Vision loss	Yes	No	Heavy menstrual bleeding	Yes	No	**IMMUNOLOGICAL**		
RESPIRATORY			Pain with menstruation	Yes	No	Allergic rhinitis (hay fever)	Yes	No
Known TB exposure	Yes	No	Vaginal discharge	Yes	No	Environmental allergies	Yes	No
Shortness of breath	Yes	No	Vaginal itching	Yes	No	Food allergies	Yes	No
Sputum	Yes	No	**HEMATOLOGIC**			Hives	Yes	No
Use of accessory muscles	Yes	No	Easy bleeding	Yes	No			
Wheezing	Yes	No	Easy bruising	Yes	No			
Whistling when breathing	Yes	No	Red or purple spots	Yes	No			
			Swollen lymph nodes	Yes	No			

5100-0029
(10/2015)