Banner Health®

NEW PATIENT HEALTH HISTORY
PEDIATRIC SURGERY

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

Person filling out form and relationship to patient: _____

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: (When did it start? How long has it been present? What things make it worse or better? Have you tried any treatment?): _____

_____

_____

Does your child have a condition requiring follow up with a specialist or other doctor? ❑ Yes ❑ No If yes, explain: _____

_____

Name of specialist/doctor: _____

ALLERGIES

❑ **No known allergies** List any allergies and intolerances to medications, food or the environment (including latex or metal).

Allergy	Reaction

MEDICATIONS

❑ **No medications** List any medications your child is taking, with dose and how often. Include any vitamins, supplements and over the counter medicines.

Medication Name	Dose	How often?

IMMUNIZATIONS

❑ Immunization history unknown ❑ Immunization up-to-date ❑ No immunizations by choice

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9999-0133
(01/2017)

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PATIENT MEDICAL HISTORY

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

❑ _____

❑ _____

❑ _____

❑ _____

SURGERIES AND/OR HOSPITALIZATIONS

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

Date	Reason	Date	Reason

DIAGNOSTIC TESTS

List any X-Ray or ultrasound test your child has had recently along with the date and location

Date	Location	Test

FAMILY HISTORY

List health conditions for each family member.

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

Does anyone in the family have difficulty with anesthesia? ❑ Yes ❑ No If yes, explain: _____

Does anyone in the family have bleeding problems? ❑ Yes ❑ No If yes, explain: _____

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SOCIAL HISTORY

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

Child attends school: _____ Grade: _____ ❑ Not applicable

Extracurricular activities/sports: _____

Father's occupation: _____

Mother's occupation: _____

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

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

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients 13 and older)

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Do you use alcohol? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use Caffeine? No _____ Yes _____ Type _____ Amount _____ Frequency _____

BIRTH HISTORY

(Complete if patient under 2 years old)

Birth Weight: _____ lbs. _____ oz. Type of delivery: ❑ Vaginal ❑ C-Section

Gestational age at birth: _____ weeks

Any complications during pregnancy? ❑ Yes ❑ No If yes, explain: _____

Any complications at birth? ❑ Yes ❑ No If yes, explain: _____

Feeding: Breast / Bottle / Both Number of feeds/day: _____

MENSTRUAL HISTORY

(Females 10 and older)

Has your child ever had a menstrual period? ❑ Yes ❑ No If yes, age of onset: _____ Date of last period: _____

Are they regular (every month)? ❑ Yes ❑ No If no, explain: _____

Length of period? ❑ less than 5 days ❑ 5-7 days ❑ more than 7 days Character of bleeding: ❑ Light ❑ Moderate ❑ Heavy

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REVIEW OF SYSTEMS

CONSTITUTIONAL			VASCULAR			PSYCHIATRIC		
Chills	Yes	No	Cool extremities	Yes	No	Behavioral changes	Yes	No
Decreased activity	Yes	No	Cyanosis (blue/purple skin)	Yes	No	Depression	Yes	No
Decreased appetite	Yes	No	Edema (swelling)	Yes	No	Difficulty concentrating	Yes	No
Fatigue	Yes	No	**GASTROINTESTINAL**			Distorted body image	Yes	No
Fever	Yes	No	Abdominal pain	Yes	No	Learning issues	Yes	No
Fussiness	Yes	No	Bloody Stool	Yes	No	Self-conscious	Yes	No
Irritability	Yes	No	Constipation	Yes	No	**SKIN**		
Lethargy	Yes	No	Diarrhea	Yes	No	Acne	Yes	No
Weight gain	Yes	No	Feeding issues	Yes	No	Eczema	Yes	No
Weight loss	Yes	No	Heartburn	Yes	No	Itching	Yes	No
HEENT			Indigestion	Yes	No	**MUSCULOSKELETAL**		
Difficulty swallowing	Yes	No	Liver issues	Yes	No	Bone pain	Yes	No
Earaches/Drainage	Yes	No	Reflux	Yes	No	Joint pain	Yes	No
Eye redness	Yes	No	Vomiting	Yes	No	Joint swelling	Yes	No
Hearing loss	Yes	No	Vomiting blood	Yes	No	Muscle pain	Yes	No
Nasal congestion	Yes	No	**GENITOURINARY**			Muscle weakness	Yes	No
Pharyngitis	Yes	No	Blood in urine	Yes	No	**HEMATOLOGIC**		
Vision problems	Yes	No	Decrease in urine output	Yes	No	Bleeding problems	Yes	No
RESPIRATORY			Enuresis	Yes	No	Easy to bruise	Yes	No
Cough	Yes	No	Flank pain	Yes	No	Red or purple spots	Yes	No
Known TB exposure	Yes	No	Foul urine odor	Yes	No	Swollen lymph nodes	Yes	No
Shortness of breath	Yes	No	**ENDOCRINE**			**IMMUNOLOGICAL**		
Wheezing	Yes	No	Excessive output	Yes	No	Allergic rhinitis	Yes	No
CARDIOVASCULAR			Excessive thirst	Yes	No	Environmental allergies	Yes	No
Abnormal blood pressure	Yes	No	**NEUROLOGICAL**			Food allergies	Yes	No
Chest pain	Yes	No	Dizzy/light headed	Yes	No	Hives	Yes	No
Fainting	Yes	No	Frequent or recurring headaches	Yes	No	**OTHER**		
Irregular heart beat	Yes	No	Seizures	Yes	No	Problems with anesthesia	Yes	No
Murmur	Yes	No						

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