Patient History Questionnaire

Children's Surgical Specialty Group
Children's Plastic Surgery

Date: ____________________

Patient Name: ____

Date Of Birth ________________________________ **Age** ___________ **years,** _________**months**

Home PH _________________________________ **Cell PH** _____________________________________

E-Mail Address ____

Primary Care Physician (PCP) ____

PCP's Address ____

PCP's Phone Number (_______) ____________________

Name of person filling out form: _____________________________________ Relationship to patient: ________________________

Patient Accompanied By: ____

What problem would you like us to evaluate today: ____

Exposure within last 30 days: (**circle**) Measles Mumps, Chicken Pox Tuberculosis Resistant Bacteria None Other: _____________

Prior Injuries: __ No __ Yes (please state type of injury, date and treatment): ____

Prior X-rays: __ No __ Yes (please state type of x-ray and date): ____

Prior Illnesses: __ No __ Yes (please state illness, dates, treatment and duration): ____

Prior Surgeries __ No __ Yes (please state type of surgery and date):____

Current Injury Date: _________________________________ External cause of injury: ______________________________________

Allergies:

Allergies to Medications? __ No __ Yes (please list medication and reaction to that medication)

____

Allergies- Food and/ or Environmental? __ No __ Yes (please list reaction) ____

Allergies to Latex? __ No __ Precautions Only __ Yes (please explain reaction) ____

Past Medical History/Problems/Surgeries/Hospitalizations: ____

____

School Information:

Name of School: ____ Current grade: _________________

Social History:

Hobbies/Sports/Activities: ____

Who lives in the home? ____

Birth History (New patient only):

Prenatal issues: ____

Was the pregnancy full term? __No __Yes

If no, number of weeks or months ____

Any complications with the delivery? __No __Yes

If yes, explain ____

Birth Weight: ____________________________ Comments: ____

Mode of Delivery: __ Vaginal __ C-section

Position: __ Vertex __ Breech

Length at Birth: ____

Any complications during the newborn period? __No __Yes

If yes, explain ____

Is your child adopted? __ No __ Yes

Does your child have an identical twin? __ No __ Yes

Adolescent Health: (If applicable)

Menarche Onset _________________ Last Menstrual Period: _____________________