NEW SURGERY PATIENT HISTORY

Patient Name: ____ **Date of birth:**___________________
Person completing form: __________________________________ **Relation:** _______________________
Primary Care Provider: ____
Preferred pharmacy & location: ____

REASON FOR VISIT: ____

SOCIAL HISTORY: Grade in school: _________With whom does patient live? ______________________________

Siblings_____________ Parents Occupation____

BIRTH HISTORY:
Birth weight: ______lb ______oz Gestation Age: How many weeks? _______ Full term ☐ Premature ☐
Delivery: Vaginal ☐ C-section ☐ Complications? No ☐ Yes ☐ ___________________________________
Medical problems for baby after delivery? No ☐ Ye s ☐ ____

IMMUNIZATIONS: Is patient up to date? No ☐ Yes ☐

SURGERIES: No ☐ Yes ☐ If yes, list the type and date. ____

HOSPITALIZATIONS: No ☐ Yes ☐ If yes, list the type and date. ____

MEDICATIONS/SUPPLEMENTS: No ☐ Yes ☐ If yes, list the name and dose. _______________________________

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Medication Allergies: No ☐ Yes ☐ If yes, list the name& reaction____
Family History: Bleeding or clotting problems (e.g. Hemophilia) No ☐ Yes ☐
Anesthetic Problems (e.g. Malignant Hyperthermia) No ☐ Yes ☐

REVIEW OF SYSTEMS: Does your child have any of the following now or in the past?

Constitutional	**No**	**Yes**
Unusual weight loss	☐	☐
Repeated unexplained fevers	☐	☐
Allergies		
Seasonal allergies	☐	☐
Food allergies	☐	☐
If yes, please list ______________		
Blood/Circulation		
Anemia	☐	☐
Bleeding tendencies	☐	☐
Sickle cell trait/disease	☐	☐
Cardiovascular		
Heart Problems	☐	☐
If yes, explain _____________		
Dermatology		
Skin rashes	☐	☐
If yes, explain ______________		
Endocrine		
Thyroid problems	☐	☐
Diabetes	☐	☐
Growth problems	☐	☐
Menstrual periods	☐	☐
LMP __________		
Ears, Nose & Throat		
Recurrent ear/sinus infections	☐	☐
Snoring	☐	☐
Eye		
Vision problems	☐	☐

GI	**No**	**Yes**
Jaundice	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Vomiting	☐	☐
Stomach pain	☐	☐
Kidney/urinary problems		
Urine infections	☐	☐
Musculoskeletal		
Joint problems	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Scoliosis	☐	☐
Broken bones	☐	☐
Respiratory		
Pneumonia	☐	☐
Asthma/Reactive airway	☐	☐
Persistent cough	☐	☐
Neuro/Developmental		
Learning disorders	☐	☐
ADHD	☐	☐
Genetic problems	☐	☐
Other___________________	☐	☐

Signature __________________________________

Date ___________________________________