Beaumont

PLASTIC & RECONSTRUCTIVE SURGERY NEW PATIENT INTAKE FORM

PEDS

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile.

PATIENT INFORMATION

Name_______________________________________ Date of Birth_____________ Gender_________

Patient's Parent / Guardian Name:____

Address____ Email __________________________

Mobile Ph ___________________ Work Ph ___________________ Home Ph ___________________

Primary Care Physician ______________________ Referring Physician _______________________

Reason for today's Visit: ____

____

Height:___________ Weight: ___________ Birth Weight: __________Full Term? NO ____ YES ____

Gestation Weeks: _______ NICU Length of stay: ______ Complications after birth: _________________

____

Does the patient attend speech therapy: NO _____ YES_____ If yes, how often?_____________________

Does the patient attend PT/OT: NO _____ YES_____ If yes, how often?_____________________

INSURANCE

Primary Insurance______________________________ Policy # _______________________________

Secondary Insurance ___________________________ Policy # _______________________________

ALLERGIES

Does the patient have any **medication allergies**, a **latex allergy** or any other allergies? If so, list all here:

____

____

MEDICATION INFORMATION

PLEASE LIST ALL **CURRENT MEDICATIONS** THE PATIENT IS TAKING:

____

____

____

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____

SURGICAL HISTORY

Has the patient had plastic surgery before? NO_____ YES_____ If yes, please list type and name of surgeon:

____

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Please list all other surgeries the patient has had:

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HEALTH HISTORY

Please check all that apply to the patient:

[ ] Asthma
[ ] Respiratory Problems
[ ] Pneumonia
[ ] Snoring / Sleep Apnea
[ ] Eye Problems
[ ] Ear Infections
[ ] Anemia / Bleeding
[ ] Hemangioma
[ ] Vascular Lesions & Birthmarks
[ ] Skin Disease / Rash
[ ] Thyroid Disorder
[ ] Feeding Difficulty
[ ] Weight gain/loss
[ ] Speech Problems

[ ] Hemifacial Microsomia
[ ] Goldenhar Syndrome
[ ] Pierre Robin Sequence
[ ] Treacher Collins Syndrome
[ ] Craniosynostosis
[ ] Cleft Lip
[ ] Cleft Palate
[ ] Apert Syndrome
[ ] Staph Infection / MRSA
[ ] Limbs, Hands, Finger Issues
[ ] Hernia
[ ] Heart Murmur
[ ] Cardiac Condition
[ ] Anesthesia Issues

[ ] Seizure Disorder
[ ] Cerebral Palsy
[ ] Developmental Delay
[ ] Autism Spectrum Disorder
[ ] Hydrocele
[ ] Kidney Disease
[ ] Urinary Tract Infection
[ ] G.I. Disease
[ ] Undescended Testicle
[ ] Incontinence
[ ] Diarrhea
[ ] Constipation
[ ] Cancer- Type: ____________
[ ] Any Other: ______________

If the patient has family with any of the above health history, please list them below next to the family relationship:

Father ____

Mother ____

Grandfather ____

Grandmother ____

Siblings ____

Other ____