Kids Plastic Surgery
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Mercy

Pediatric Medical History

Patient Information	
Patient Name:	Today's' Date:
Date of Birth:	Medical Record Number:

Reason For Visit
Brief history of problem(s) to be evaluated today (what, where, when, how long, and other factors):
Why did you come to the Doctor, and where on the body is the problem?
How long has the problem been present?
What problems does it cause the child? (pain, itching, chewing problems, teasing, etc.)

Mother's Pregnancy History	
Child's birth weight _____lbs ____ ozs	Child's Current Weight _____lbs ____ozs
Number of children born to mother:	Total number of pregnancies:
Mother's age at Child's birth:	Father's age at Child's birth:
Check all that apply to his Child: ☐Adopted ☐Premature (____weeks early) ☐Full Term ☐IVF/Other Conception ☐Vaginal Delivery ☐C-section, if so why done? ☐Breech ☐Labor didn't progress ☐Baby's size ☐Change in Baby's heart rate	
Explain any complications with pregnancy or delivery: ☐None ☐Twin or Multiple pregnancy ☐Mother smoked during pregnancy ☐Mother drank alcohol during pregnancy ☐Mother used drugs during pregnancy ☐Mother received regular prenatal care ☐Mother took prenatal vitamins during pregnancy	

Child's Medical History
Current Medications: ☐None List both prescription and non-prescription medications include how long each has been taken, strength,and how often.
Allergies: ☐None List all allergies to medications or other food/environmental substances and the reaction(s)
Medical Problems: ☐None List all chronic medical conditions (for example, problems with the heart, lungs, liver, kidneys, bleeding problems, etc.

Previous Operations: ☐None List procedures and approximate dates	Hospitalizations: ☐None List reasons and approximate dates

Significant Injuries: ☐None List problems and approximate date below ☐Car accidents ☐Burns ☐Broken Bones ☐Unconscious or concussion ☐Other	Immunizations up to date? ☐Yes ☐No
Menstrual History: (Female Patients only) Age at first period:	Regular periods: ☐Yes ☐No Is Teen sexually active: ☐Yes ☐No Is Teen using birth control: ☐Yes ☐No

Patients over 13 years old Any Tobacco Use ☐Yes ☐No Drug Use ☐Yes ☐No Alcohol Use ☐Yes ☐No	Is child exposed to second hand smoke? ☐Yes ☐No

Family History

Do any of your Child's family members have the following?

Problem	Who has it?	Problem	Who has it?
☐Cleft Lip	_____	☐Jaw Problems	_____
☐Cleft Palate	_____	☐Melanoma or Mole Cancer	_____
☐Skull or Face Problems	_____	☐Heart Disease	_____
☐Keloids or Unusual Scars	_____	☐Breast Cancer	_____
☐Ear Shape Problems	_____	☐Problems with Anesthesia	_____
☐Other (describe briefly)			

Problem List

Please check **ALL** boxes if it does not apply to your child check NO :

General:		**Behavior and Development:**	
Recurring Fevers	☐Yes ☐No	Speech Problems	☐Yes ☐No
Fainting or Dizzy Spells	☐Yes ☐No	Feeding or Chewing Problems	☐Yes ☐No
Thirsty all the time	☐Yes ☐No	Learning Problems or Development delay	☐Yes ☐No
Severe headaches or Seizure	☐Yes ☐No	Attention Deficit or Hyperactivity Disorder	☐Yes ☐No
Large weight loss or weight gain	☐Yes ☐No	Depression or	

Sleep:

Snoring or noisy breathing during sleep ☐Yes ☐No
Observed apnea or breath holding ☐Yes ☐No
Restless sleep ☐Yes ☐No
Daytime sleepiness or hyperactivity ☐Yes ☐No
Other concern: _____

Other Psychiatric problem ☐Yes ☐No
Chromosomal Abnormality ☐Yes ☐No

Head, Eyes, Ears, Nose, Throat, Neck:

Ear shape or Size problem ☐Yes ☐No
Hearing Problem ☐Yes ☐No
Frequent Earaches or Infections ☐Yes ☐No
Frequent Runny nose or Sore Throat ☐Yes ☐No
Frequent Nose Bleeds ☐Yes ☐No
Severe Dental Problems ☐Yes ☐No
Problems with Jaws or Mouth opening ☐Yes ☐No
Skull or Facial Abnormality ☐Yes ☐No
Cleft Lip or Cleft Palate ☐Yes ☐No
Neck muscle tightness ☐Yes ☐No
Wears Glasses/Contacts ☐Yes ☐No

Skin:

Wound healing problem ☐Yes ☐No
Vascular Birthmark or Hemangioma ☐Yes ☐No
Keloids or unusual scars ☐Yes ☐No
Melanoma or skin cancer ☐Yes ☐No
Pigmented skin lesions ☐Yes ☐No
Cutis Aplasia ☐Yes ☐No
Neurofibromatosis ☐Yes ☐No

Bones/Muscles:

Spina Bifida ☐Yes ☐No
Muscle weakness or spasticity ☐Yes ☐No
Arthritis ☐Yes ☐No

Chest:

Heart Abnormality at Birth ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Asthma ☐Yes ☐No

Blood and Glands:

Hemophilia ☐Yes ☐No
Diabetes ☐Yes ☐No
Immune System Problem ☐Yes ☐No
Clotting Disorder ☐Yes ☐No
Anemia ☐Yes ☐No

Stomach/Abdomen:

Frequent Pain ☐Yes ☐No
Frequent Diarrhea or Constipation ☐Yes ☐No
Frequent Nausea/Vomiting ☐Yes ☐No
Blood in Stool or Urine ☐Yes ☐No

Other: