Children's HOSPITAL • ST. LOUIS

Washington University in St. Louis SCHOOL OF MEDICINE

Pediatric Plastic Surgery Initial Consultation History

PATIENT AND REFERRAL INFORMATION

Patient's Name _____ Date of Visit _____

Patient's Date of Birth _____ Patient's Age _____ Time Arrived _____

Name of Person Filling out Form _____ Relationship to Child _____

Person with Legal Custody of Child _____ Relationship to Child _____

If referred to this visit:

Referring Doctor's Name _____

Referring Doctor's Address _____

Referring Doctor's Specialty (please check one or fill in):

☐ Pediatrics ☐ Family Medicine ☐ Dermatology ☐ Other _____

If not referred, how did you choose this office? _____

Patient comes today with (please check all applicable):

☐ Mother ☐ Father ☐ Grandparent(s) ☐ Other _____

REASON(S) 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 this Child: ☐ Adopted

☐ Premature: How many 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

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CHILD'S PAST MEDICAL HISTORY

CURRENT MEDICATIONS ☐ **None**

List both prescription and non-prescription medications and how long each has been taken.

Medicine	*How Long Taken*	*Medicine*	*How Long Taken*

ALLERGIES ☐ **None**

List all allergies to medications or other food/environmental substances and the reaction(s) caused.

Allergen	*Reaction*	*Allergen*	*Reaction*

MEDICAL PROBLEMS ☐ **None**

List all chronic medical conditions (for example, problems with the heart, lungs, liver, kidneys, bleeding problems, etc.)

PREVIOUS OPERATIONS ☐ **None** List procedure(s) and approximate date(s).

Procedure	*Date*	*Procedure*	*Date*

HOSPITALIZATIONS ☐ **None** List reason(s) and approximate date(s).

Reason	*Date*	*Reason*	*Date*

SIGNIFICANT INJURIES ☐ **None**

List problem(s) and approximate date(s).

☐ Car Accident(s)_____ ☐ Burn(s)_____ ☐ Broken Bones_____ ☐ Unconscious or concussion _____

☐ Other _____

IMMUNIZATIONS Up to Date? ☐ Yes ☐ No

MENSTRUAL HISTORY (Female Patients Only)

Age at first menstrual period _____ Regular periods: ☐ Yes ☐ No

Is Teen sexually active? ☐ Yes ☐ No Is Teen using birth control? ☐ 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) _____

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PROBLEM LIST

Please check all that apply to the Child and provide a brief explanation of items checked.

General:

Recurring Fevers ☐ Yes ☐ No _____
Large Weight Loss or Weight Gain ☐ Yes ☐ No _____
Fainting or Dizzy Spells ☐ Yes ☐ No _____
Thirsty all the Time ☐ Yes ☐ No _____
Severe Headaches or Seizures ☐ Yes ☐ No _____
Frequent Sleeping Troubles ☐ Yes ☐ No _____
Loud Snoring or Sleep Apnea ☐ Yes ☐ No _____
Tired all the Time ☐ Yes ☐ No _____

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

Ear Shape or Size Problem ☐ Yes ☐ No _____
Hearing Problem ☐ Yes ☐ No _____
Frequent Earaches or Ear 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 _____

Chest:

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

Behavior and Development:

Speech Problems ☐ Yes ☐ No _____
Feeding or Chewing Problems ☐ Yes ☐ No _____
Learning Problem or Developmental Delay ☐ Yes ☐ No _____
Attention Deficit or Hyperactivity Disorder ☐ Yes ☐ No _____
Drinks Alcohol or Uses Drugs or has Substance Abuse Problem ☐ Yes ☐ No _____
Cigarette Smoker ☐ Yes ☐ No _____
Depression or Other Psychiatric Problem ☐ Yes ☐ No _____
Chromosomal Abnormality ☐ 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 _____

Blood and Glands:

Hemophilia ☐ Yes ☐ No _____
Diabetes ☐ Yes ☐ No _____
Immune System Problem ☐ Yes ☐ No _____
Other Problems (specify) ☐ Yes ☐ No _____

_____
_____
_____

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OTHER INFORMATION

Social History

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Not Married

Best Contact Phone Number ( ) _____ Patient lives with _____

Father's Occupation _____ Mother's Occupation _____

Child is in: ☐ Public School ☐ Private School ☐ Home Schooled Grade Level _____

In what activities does the child participate after school? _____

Have there been any recent events at home or in the child's life that may affect her/his health or well being? _____

_____

_____

Is there any other information about this child that you feel is important to add? _____

_____

SIGNATURE AND PHOTOGRAPHIC CONSENT

Signature of Person Filling Out Form

I certify that I have filled out this form truthfully to the extent of my knowledge.

X _____ _____

Signature of person filling out form Date

Permission For Photography And Release:

I hereby voluntarily grant permission to the Doctors of the Division of Plastic Surgery at Saint Louis Children's Hospital and her/his designated representatives to take and use clinical photographs of my child(ren) with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor. Occasionally, such photographs are used for teaching purposes, research, medical publications, medical as well as public education, and for patient information and education.

If your child's photograph is used for publication, you will be notified BEFORE any publication is produced. Otherwise, photographs are for our records only.

X _____ _____

Signature of patient/parent/legal guardian Date

FOR OFFICE USE ONLY

_____ _____

All 4 pages of this form reviewed by Date