AdventHealth

PATIENT INTAKE FORM

AHMG Plastic & Reconstructive Surgery

PHYSICIAN: Dr. Rajendra Sawh-Martinez

PEDIATRIC PLASTIC SURGERY HISTORY AND INTAKE FORM **Today's Date:**

PATIENT NAME:	DOB:	AGE/GENDER:

WHAT ARE WE SEEING YOU FOR TODAY?

STREET ADDRESS:	CITY/STATE:	ZIP CODE:	PHONE NUMBER:
EMAIL ADDRESS:	EMERGENCY CONTACT:	PREFERRED LANGUAGE:	RACE/ETHNICITY:

PEDIATRICIAN: Office Phone:	REFERREING PHYSICIAN: Office Phone:

PREFERRED PHARMACY:	PHONE NUMBER:	CITY, STATE, ZIP CODE:
Parent 1/Gaudian/Mother Name: Phone:	Parent 2/Guardian/Father's Name: Phone:	Emergency Name/Relationship/contact info (if other):

CRANIOFACIAL & PEDIATRIC

- □ Cleft Lip
- □ Cleft palate
- □ Craniosynostosis
- □ Craniofacial Syndrome
- □ Hemangioma
- □ Facial fracture
- □ Facial Laceration
- □ Ear Anomaly
- □ Ear Molding
- □ Otoplasty (Ear Pinning)
- □ Fat Grafting
- □ Bone Grafting
- □ Rhinoplasty
- □ Jaw Surgery
- □ Speech Surgery (VPI)
- □ Vascular Growth
- □ Congenital Growth
- □ Facial Asymmetry
- □ Other: _____

BREAST

- □ Breast Reconstruction
- □ Breast Asymmetry
- □ Breast Reduction
- □ Breast Augmentation
- □ Breast Lift (Mastopexy)
- □ Breast Revision/Repair
- □ Breast implant exchange
- □ Breast Capsulectomy
- □ Male Breast (Gynecomastia)
- □ Other:_____

BODY

- □ Abdominal Wall Recon
- □ Perineal Reconstruction
- □ Liposuction
- □ Tummy Tuck (Abdominoplasty)
- □ Panniculectomy
- □ Mommy Makeover
- □ Other:

SKIN

- □ Vascular Anomalies
- □ Nevus Sebaceous
- □ Other Nevus (skin lesion)
- □ Pigmented Lesion
- □ Mole (skin mass)
- □ Keloid
- □ Body Laceration/wound
- □ Botox Injections
- □ Fillers
- □ Other:_____

Key Surgical Family Medical History (please check all that apply)

Cleft & Craniofacial Disorders

Does your family have a history of Cleft or Craniofacial Disorders? □Yes □No If so, which relative?

□ Mother □ Father □ Sister □ Brother □ Daughter □ Son □ Uncle □ Aunt □ Nephew □ Niece □ Grandmother □ Grandfather □ Grandson □ Granddaughter □ Other_____

Breast Cancer

Does your family have a history of breast cancer? □ Yes □ No If so, which relative?

□ Mother □ Father □ Sister □ Brother □ Daughter □ Son □ Uncle □ Aunt □ Nephew □ Niece □ Grandmother □ Grandfather □ Grandson □ Granddaughter □ Other_____

Melanoma

Does your family have a history of Melanoma? □Yes □No If so, which relative?

□ Mother □ Father □ Sister □ Brother □ Daughter □ Son □ Uncle □ Aunt □ Nephew □ Niece □ Grandmother □ Grandfather □ Grandson □ Granddaughter □ Other_____

Malignant Hyperthermia and Anesthesia Sensitivity

Does your family have a history of malignant hyperthermia or severe reactions to anesthesia? □Yes □No

If so, which relative?

□ Mother □ Father □ Sister □ Brother □ Daughter □ Son □ Uncle □ Aunt □ Nephew □ Niece □ Grandmother □ Grandfather □ Grandson □ Granddaughter □ Other_____

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PAST SURGERIES	DATE OF SURGERY

List any MEDICATIONS & HERBAL SUPPLEMENTS your child is taking at this time. Include such items as aspirin, vitamins, laxatives, etc. (May write at end if not enough space)

NAME OF MEDICATION	DOSE (Include strength and # per day)	NAME OF MEDICATION	DOSE (Include strength and # per day)
1.		4.	
2.		5.	
3.		6.	

Past Medical History –
Select any of the following medical conditions your child currently has (please check all that apply)

□ Anxiety	□ COPD	□ Hypertension	□ Other Pediatric Cancer
□ Autism	□ Congenital Heart Disease	□ HIV/AIDS	□ Radiation treatment
□ Asthma	□ Depression	□ Hypercholesterolemia	□ Seizures
□ ADHD	□ Diabetes	□ Hyperthyroidism	□ Speech Disturbances
□ Bone Marrow Transplant	□ Endocrine Disorder(s)	□ Hypothyroidism	□ Strabismus
□ Breathing disorders	□ GERD	□ Leukemia	□ Stroke
□ Breast Cancer	□ Hearing Loss	□ Lung Cancer	□ Syndromes (ie Genetic, Down, Trisomy)
□ Chest Pain/Palpitations	□ Hepatitis	□ Lymphoma	□ Visual Disturbance/glasses

□ **OTHER**

ALLERGIES (Please list ALL allergies; May use space at end if needed)

Social History (PARENTS & child if applicable) (please check all that apply)

□ PARENTS or Patient - Never Smoked □ Currently smokes – not daily □ Currently smokes – daily

□ Started Smoking (MM/YYYY): Quit Smoking (MM/YYYY): Number of packs per day: Total years Smoking:

□ Has smoked in the past	□ Drug use	□ IV drug use	□ None
□ Not sexually active	□ EtoH none	□ EtoH < 1 drink per day	□ Patient feels safe at home
□ Sexually active with one partner	□ EtoH 1-2 drinks per day		□ Patient feels unsafe at home
□ Sexually active with more than one partner	□ EtoH 3+ drinks per day		□ Other Disclosure:

Birth & Pregnancy History

Gestational Age at Birth (weeks):	Birth Weight:	Birth Height:	APGARs:

Type of Delivery (circle): Vaginal C-Section Emergent Induced Use of Forceps/Suction?: Y/N

Maternal Illness/Exposures during Pregnancy : None Diabetes Hypertension Other: _____

Parent Occupation/Employment:: _____ HIGHEST EDUCATION: _____

HOBBIES: _____ RELIGIOUS PREFERENCE: _____

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Review of Systems: Is your child CURRENTLY experiencing any of the following? (please check yes or no for the following)					
Problems with bleeding	□YES □NO	Bloody urine	□YES □NO	Muscle weakness	□YES □NO
Problems with healing	□YES □NO	Blurry vision	□YES □NO	Neck stiffness	□YES □NO
Problems with scarring	□YES □NO	Chest pain	□YES □NO	Night sweats	□YES □NO
Immunosuppression	□YES □NO	Cough	□YES □NO	Seizures	□YES □NO
Changing Mole	□YES □NO	Depression	□YES □NO	Shortness of breath	□YES □NO
Rash	□YES □NO	Fever or chills	□YES □NO	Sore throat	□YES □NO
Abdominal pain	□YES □NO	Headaches	□YES □NO	Thyroid problems	□YES □NO
Anxiety	□YES □NO	Hay Fever	□YES □NO	Unintentional weight loss	□YES □NO
Bloody stool	□YES □NO	Joint aches	□YES □NO	Wheezing	□YES □NO

Alerts (please check any that you have experienced)		
□ Pacemaker	□ Blood thinners	□ West Africa: Travel or contact □ Ebola Risk: Fever > = 100.4 degrees □ Ebola Risk: Resided or Traveled to Country-wide spread Ebola transmission in last 21 days
□ Defibrillator	□ Pregnancy or planning a pregnancy	
□ Artificial joints within past 2 years	□ Allergy to lidocaine	
□ Artificial heart valve	□ Rapid Heart Beat with epinephrine	
□ Premedication prior to procedures	□ Yeast infections with antibiotics	□ History of Cold Sores
□ Allergy to adhesive	□ GI upset with antibiotics	□ History of Accutane
□ Allergy to topical antibiotic ointments	□ Other:	

Additional Medical/Surgical/Medication History:

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Representative Name (print)_____ Signature_____ Date_____

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