Boston Children's Hospital | Plastic and Oral Surgery
Until every child is well™

Name Used	Legal Name
_____	_____
Preferred Pronouns	D.O.B.
_____	_____

Referring Physician:_____ **Patient Age:**_____

Reason for today's visit:_____

Preferred Pharmacy Name and Location:_____

Birth History (INFANT PATIENTS ONLY):_____**Birth Weight:**_____

Medical History (Past and Current Conditions):

1. 3.
2. 4.

Surgical History (Previous Operations):

1.
2.

Medications (Current):

1. 3.
2. 4.

Allergies (Medication, Seasonal, and Food):

1.
2.

Family History:

Family/personal history of an adverse reaction to anesthesia? Y/N

Please list any significant family medical history:

Disease or illness:	Relation to patient:
1. _____	_____
2. _____	_____

Social History: (Please circle):

Recent high-risk travel? Yes No

Exposure to tobacco at home? Yes No

ADULT PATIENTS:

Occupation: _____

Do you smoke, vape or chew tobacco? Yes No

Do you drink alcohol? Yes No

Are you pregnant? Yes No

Does the patient have or ever had any of the following?

	Please Circle:	
Respiratory Problems/Asthma	Yes	No
Liver Disease	Yes	No
Tuberculosis	Yes	No
Hepatitis	Yes	No
Diabetes	Yes	No
Neurological Disorders	Yes	No
Thyroid Disorder	Yes	No
Epilepsy or Seizure Disorder	Yes	No
Heart Problem	Yes	No
Migraine Headaches	Yes	No
High Blood Pressure	Yes	No
Psychiatric Disorders	Yes	No
Kidney Disorder	Yes	No
Sexually Transmitted Disease	Yes	No
Stomach Disorder/Ulcer	Yes	No
HIV/ARC/AIDS	Yes	No
Cancer or other Tumors	Yes	No
Significant weight changes	Yes	No
Blood Disorder	Yes	No
Eating Disorder	Yes	No

Clinician Notes:

Height: _____ *Weight:* _____ *BMI:* _____

Heart Rate: _____ *Blood pressure:* _____

Is the patient in pain? (Circle): Yes No

_____ _____ _____

Patient/ Parent/ Guardian Signature (If patient under 18 years of age) **Print** **Date**

Provider Signature_____ **Print Name** _____ **Date** _____