

ST JOSEPH'S CHILDREN'S CRANIOFACIAL CENTER

PATIENT NAME _____

1. Medical problems? _____

2. Surgical history? (include age, surgeon, and operation) _____

3. Drug or food allergies? _____

4. Medications (and doses)? _____

5. Does your child have a syndrome or genetic disorder? _____

6. Is your child up to date on immunizations ("shots")? _____

7. What is your child's weight? _____

8. Development? ("slow learner?") _____

9. Has your child ever had:	YES	NO		YES	NO
Hearing Loss	___	___	Cystic Fibrosis	___	___
Sickle Cell Disease	___	___	Muscular Dystrophy	___	___
Rheumatic Fever	___	___	Cerebral Palsy	___	___
Tuberculosis	___	___	Diabetes	___	___
Anemia	___	___	Frequent Vomiting	___	___
Arthritis	___	___	Blood Transfusion	___	___
Thyroid Disease	___	___	Seizures/ Epilepsy	___	___
Spina Bifida	___	___	Kidney Problems	___	___
Hepatitis	___	___	Problems with anesthesia	___	___
Heart disease	___	___	Heart Murmur	___	___
Asthma	___	___	Steroid medicines	___	___

Birth History:

1. Did the child's mother have a "normal" pregnancy? _____

2. Was the baby delivered via cesarian section? If so, why? _____

3. Was your child premature? How many weeks? _____

4. How much did your child weigh at birth? _____

5. Did your child have to stay in the ICU? How long? _____

6. What is your primary concern today? _____

Parent's (Guardian) Signature

Date

Doctor's Signature

Date