New Patient Intake Form

AHMG Plastic & Reconstructive Surgery at Orlando
AHMG Pediatric Head & Neck Surgery

AdventHealth Medical Group

Dr Joseph Lopez, MD, MBA

Today's date:	**What are we seeing you for today?**	
Patient name:	DOB:	Age/Gender:
Street Address:	City/State:	Zip code:
Phone Number:	Email:	
Emergency Contact:	Preferred Language:	
Race/Ethnicity:	Pediatrician:	Office Phone:
Referring Physician:	Office Phone:	
Preferred Pharmacy:	Phone Number:	City/State/ Zip code:
Parent 1/ Guardian/ Mother Name:	Phone number:	
Parent 2/ Guardian/ Father Name:	Phone Number	

Craniofacial & Pediatric **Please circle all that apply:**	**Body**	**Skin**
Bone Grafting Cleft Lip Cleft Palate Craniosynostosis Craniofacial syndrome Ear Anomaly Ear Molding Facial Asymmetry Facial Fracture Facial laceration Fat Grafting Hemangioma Jaw Surgery/Orthognathic Surgery Otoplasty (Ear Pinning) Rhinoplasty Speech Surgery Other:	Abdominal Wall Reconstruction Lower extremity Reconstruction Perineal Reconstruction Other:	Body Laceration/wound Botox Injections Fillers Keloid Mole (skin mass) Nevus Sebaceous Other Nevus (skin lesion) Pigmented Lesion Skin Cancer Type: _____ Vascular Anomalies AV Malformation Lymphatic Malformation Venous Malformation Other:

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Head & Neck **Please circle all that apply:**	**Thyroid**
Brachial cleft cyst Dental Cyst Type:_____ Dental bone tumor KCOT Giant Cell Other:_____ Encephalocele Intra-oral Cancer Type: ____ Juvenile Nasopharyngeal angiofibroma Migraine Neuroblastoma Salivary tumor Sarcoma Schwannoma Other:____ TMJ	MEN2 Other:____ Graves' disease Thyroglossal cyst Thyroid Cancer Type:____ Thyroid Nodule

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 Head & Neck Tumors? □ 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_____

Past surgeries	**Date of Surgery**

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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.		1.	
2.		2.	
3.		3.	

Past Medical History

Select any of the following medical conditions your child currently has (please circle 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 (i.e., 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 circle 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:

Not sexually active	EtoH none EtoH < 1 drink per day	Patient feels safe at home
Sexually active with one partner Sexually active with more than one partner	EtoH 1-2 drinks per day EtoH 3+ drinks per day	Patient feels unsafe at home
		Other Disclosure:

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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 Level Education:	
Hobbies:		Religious Preference:	

Review of Systems: Is your child CURRENTLY experiencing any of the following? (Please circle 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 Circle all that apply)		
Pacemaker	Blood thinners	History of Cold Sores
Defibrillator	Pregnancy or planning a pregnancy	History of Accutane
Artificial joints within past 2 years	Allergy to lidocaine	Hoarseness
Artificial heart valve	Rapid Heartbeat with epinephrine	
Premedication prior to procedures	Yeast infections with antibiotics	□ 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
Allergy to adhesive	GI upset with antibiotics	
Allergy to topical antibiotic ointments	Constipation:	
Trouble swallowing		

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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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