



Department of Neurosurgery Health Form



The purpose of the Children's Hospital General Health Form is to ensure that all patients go through their visit as quickly and smoothly as possible. The more information you can provide to us, the more efficient we can make your appointment. ***

Please bring this completed form with you to your visit. ***

Last Name	First Name	M.I.	SEX
Street Address	City	State	Zip Code
Home Phone	Parent/LegalGuardian		
Work Phone	Date of Birth	Date of Planned Surgery if required	

Name of Pediatrician/Primary Care MD		Name of Neurosurgeon (if surgery is needed)	
Phone #	Fax #	Phone #	Fax #

ANESTHESIA/SURGERY HISTORY

1. Has the patient ever had any surgery (both day and or overnight), been hospitalized (medical, psychiatric, substance abuse etc.)? Yes No If yes, please summarize giving dates and description: _____

2, Has the patient ever had either general anesthesia or sedation? Yes No If yes, were any problems noted? Please summarize: _____

3. Is there a family history of problems with anesthesia? Yes No If yes, please describe and provide documentation (i.e. medical records, note from anesthesia, etc.) Please summarize: _____

MEDICATIONS

4. Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)? Yes No If yes, please summarize listing medication, dosage and reason for use: _____

ALLERGIES

5. Does the patient have any allergies (including environmental, medication, food, reaction to previous blood transfusion)? Yes No If yes, please summarize describing allergy and symptoms: _____

SOCIAL HISTORY

1. Smoking pack(s) per day _____ Alcohol drinks per week _____ Drug use _____
2. Occupation _____ Do you enjoy your job? _____ (If student)Year in School _____
3. If you play Sports which sport(s) do you enjoy? _____
4. Do you exercise? _____ Hours per week? _____ Type of exercise? _____

MEDICAL HISTORY

6. Does the patient have, or has he/she ever been diagnosed with, any of the following?

Please check any that apply:

Please explain history:

BIRTH HISTORY: NSVD (Normal Spontaneous Vaginal Delivery)
 c/SEC (Caesarean Section) FT (full-term) Premature **Birth Weight** _____

PREMATURITY: Apnea Bradycardia Intubation
 ROP(Retinopathy of Prematurity)
 Mechanical Ventilation - if yes, how long? _____
 BPD (Bronchopulmonary Dysplasia)/Lung Problems _____

EAR, NOSE & THROAT: URI (Upper Respiratory Infection)/Cold
 Loose Teeth Braces Removable Oral Appliance Deafness
 Recent Strep Throat Ear Infection Snoring Blindness Apnea
 Dysphagia (Difficulty Swallowing) Sore Throat Fever _____

CARDIAC: Arrhythmia's (Irregular Heartbeat) Murmurs Palpitations
 HTN (Blood Pressure Problems) Congenital Abnormality
 Cardiotoxic Drugs _____

RESPIRATORY: Asthma Bronchitis Pneumonia Croup
 TB (Tuberculosis) Tracheostomy Chronic cough Aspiration
 RSV (Respiratory Syncytial Virus) _____

GENITOURINARY: Kidney Disease UTI (Urinary Tract Infection) _____

HEPATIC: Jaundice (yellow skin) Hepatitis Liver Disease _____

NEUROLOGIC: Seizures Weakness Hydrocephalus Migraines
 Epilepsy IVH (Intra-ventricular hemorrhage) Myelodysplasia
 Myopathy _____

GASTROINTESTINAL: GE Reflux Diarrhea Constipation Vomiting _____

MUSCULOSKELETAL: Hypotonia Muscle Disease Scoliosis
 Muscular Dystrophy Fractures Arthritis Back Pain Neck Pain _____

SKIN: Rash Birthmarks Bruises Eczema Scars Hemangioma _____

BLOOD DISORDERS: Sickle Cell Disease Bleeding Disorder
 G6PD Deficiency Prior Transfusion Anemia Leukemia
 Lymphoma Easy Bleeding/Bruising Thalassemia Other _____

ENDOCRINE/METABOLIC: Diabetes Thyroid Disorders
 Adrenal Disorders Inborn Errors of Metabolism _____

PSYCHOSOCIAL: Developmental Delay Learning Disability ADD

 Autism Substance Abuse _____

OB/GYN: Date of Last Menstrual Period: _____ Possibility of Pregnancy Yes No

7. What are the names and phone numbers of other physician's involved in your child's care? _____

Date Reviewed: _____

Height _____ Weight _____ Temp: _____

Date Reviewed: _____

Height _____ Weight _____ Temp: _____

Date Reviewed: _____

Height _____ Weight _____ Temp: _____

The previous statements are true to the best of my knowledge

Authorization to Pay Benefits:

I authorize the release of medical information necessary to process the claim and assign benefits otherwise payable to me, to Children’s Hospital Boston and any physicians associated with the care provided at Children’s. I understand that I am financially responsible for charges not covered by this assignment. I permit copy of this authorization to be used in place of the original.

Release Statement:

I authorize Children’s Hospital to release information from care provided at Children’s Hospital, in accordance with established laws, to my personal physician (s), health care provider, and I consent to this release.

Signature of Patient/Parent/Guardian

Reviewed by (MD/NP)

Witness: _____

Date: _____

