

**CHILDREN'S SURGICAL SPECIALTY GROUP – PEDIATRIC SURGERY  
PATIENT QUESTIONNAIRE**

TODAY'S DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  
First Name Middle Name Last Name

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ years, \_\_\_\_\_ months

PRIMARY CARE PHYSICIAN (PCP) \_\_\_\_\_

PCP'S ADDRESS \_\_\_\_\_  
Street Address City State Zip

PCP'S PHONE NUMBER (\_\_\_\_\_) \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

What is the problem that brings your child to the doctor's office today? \_\_\_\_\_  
\_\_\_\_\_

Has another physician other than your PCP referred you?  Yes  No If yes, please list the full name, address and phone number of that doctor:

\_\_\_\_\_  
First Name Last Name Street Address City State Zip Phone

Are there other physicians involved in your child's care?  Yes  No If yes, please list their name(s)

\_\_\_\_\_  
\_\_\_\_\_

**PAST HISTORY**

**CURRENT MEDICATIONS:**

Drug _____	Dose _____	Frequency _____
Drug _____	Dose _____	Frequency _____
Drug _____	Dose _____	Frequency _____
Drug _____	Dose _____	Frequency _____
Drug _____	Dose _____	Frequency _____
Drug _____	Dose _____	Frequency _____

**ALLERGIES TO FOODS?**  Yes  No If yes, please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO MEDICATIONS?**  Yes  No If yes, please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO METAL OBJECTS?**  Yes  No If yes, please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO LATEX?**  Yes  No

**ARE IMMUNIZATIONS UP TO DATE?**  Yes  No

**PRIOR ILLNESSES?**  Yes  No If yes, please state illness, dates, treatment and duration: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME \_\_\_\_\_

**PRIOR INJURIES?**  Yes  No If yes, please state type of injury, date and treatment: \_\_\_\_\_

**PRIOR SURGERY?**  Yes  No If yes, please state type of surgery and date: \_\_\_\_\_

**PRIOR HOSPITALIZATIONS?**  Yes  No If yes, please state dates, reasons and location: \_\_\_\_\_

**PRIOR X-RAYS?**  Yes  No If yes, please state type of x-ray and date: \_\_\_\_\_

**NUTRITIONAL CONCERNS?**  Yes  No If yes, please state your concerns: \_\_\_\_\_

**ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD'S MEDICAL HISTORY?**

**WAS PATIENT BORN AT FULL TERM/GESTATION?**  Yes  No If no, please state gestational age: \_\_\_\_\_

**WEIGHT AT BIRTH:** \_\_\_\_\_ pounds, \_\_\_\_\_ ounces

## **FAMILY HISTORY**

**ARE BOTH PARENTS ALIVE AND WELL?**  Yes  No If no, please state the deceased parent and the cause of death: \_\_\_\_\_

**HOW MANY BROTHERS AND SISTERS DOES THE PATIENT HAVE?** \_\_\_\_\_ Brothers \_\_\_\_\_ Sisters

**ARE THEY ALIVE AND WELL?**  Yes  No If no, please state the illness or cause of death: \_\_\_\_\_

**IS THERE ANY PERTINENT FAMILY MEDICAL HISTORY?**  Yes  No If yes, please provide details: \_\_\_\_\_

## **SOCIAL HISTORY**

**WITH WHOM DOES THE PATIENT CURRENTLY RESIDE?** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

**IS THE PATIENT ACTIVE IN SPORTS OR OTHER ORGANIZED ACTIVITIES?**  Yes  No If yes, please state the sport or type of activity \_\_\_\_\_

**HAS THE PATIENT HAD A HISTORY OF DRUG, ALCOHOL AND/OR TOBACCO USE?**  Yes  No If yes, please state the type and duration \_\_\_\_\_

**IS THE PATIENT SEXUALLY ACTIVE?**  Yes  No If yes, please state for how long \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

**ANY ADDITIONAL RELEVANT SOCIAL FACTORS YOU WOULD LIKE US TO KNOW ABOUT?** \_\_\_\_\_

**REVIEW OF SYSTEMS**

SYSTEM	PLEASE CHECK ALL THAT APPLY
GENERAL	<input type="checkbox"/> NONE <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Change in Appetite <input type="checkbox"/> Fainting <input type="checkbox"/> Change in Sleep Habits <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain
HEAD	<input type="checkbox"/> NONE <input type="checkbox"/> Headaches <input type="checkbox"/> Recent Trauma
EYES	<input type="checkbox"/> NONE <input type="checkbox"/> Decreased Vision <input type="checkbox"/> Pain <input type="checkbox"/> Itch <input type="checkbox"/> Dryness <input type="checkbox"/> Redness <input type="checkbox"/> Infection <input type="checkbox"/> Glaucoma <input type="checkbox"/> Double Vision <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses
EARS	<input type="checkbox"/> NONE <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Deafness <input type="checkbox"/> Discharge <input type="checkbox"/> Pain <input type="checkbox"/> Ringing <input type="checkbox"/> Dizziness
NOSE & SINUSES	<input type="checkbox"/> NONE <input type="checkbox"/> Decreased Sense of Smell <input type="checkbox"/> Bleeding <input type="checkbox"/> Dryness <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Obstruction <input type="checkbox"/> Sinusitis <input type="checkbox"/> Seasonal Allergies
THROAT & MOUTH	<input type="checkbox"/> NONE <input type="checkbox"/> Sore Throat <input type="checkbox"/> Pain <input type="checkbox"/> Infection <input type="checkbox"/> Sore Tongue <input type="checkbox"/> Ulcers <input type="checkbox"/> Blisters <input type="checkbox"/> Lip Lesions <input type="checkbox"/> Canker Sores <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Problems with Teeth
NECK	<input type="checkbox"/> NONE <input type="checkbox"/> Stiffness <input type="checkbox"/> Decreased Motion <input type="checkbox"/> Pain <input type="checkbox"/> Lumps <input type="checkbox"/> Swollen Glands
BREASTS	<input type="checkbox"/> NONE <input type="checkbox"/> Discharge <input type="checkbox"/> Bleeding <input type="checkbox"/> Retraction <input type="checkbox"/> Tenderness <input type="checkbox"/> Size
SKIN	<input type="checkbox"/> NONE <input type="checkbox"/> Rash <input type="checkbox"/> Itch <input type="checkbox"/> Color Change <input type="checkbox"/> Moles/Changes <input type="checkbox"/> Infections <input type="checkbox"/> Hair/Changes <input type="checkbox"/> Nails/Changes <input type="checkbox"/> Tumors <input type="checkbox"/> Sores <input type="checkbox"/> Hives
RESPIRATORY	<input type="checkbox"/> NONE <input type="checkbox"/> Cough <input type="checkbox"/> Chest Pain <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sputum (Color/Frequency) <input type="checkbox"/> Recurrent Infection <input type="checkbox"/> Exposure to Tuberculosis <input type="checkbox"/> Cyanosis (bluish tint to skin, lips, nails) <input type="checkbox"/> Shortness of Breath on Exercise
CARDIOVASCULAR	<input type="checkbox"/> NONE <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Fainting <input type="checkbox"/> Phlebitis <input type="checkbox"/> Varicose Veins
LYMPHATIC	<input type="checkbox"/> NONE <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Malignancy <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Transfusions
GASTROINTESTINAL	<input type="checkbox"/> NONE <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> Hernia <input type="checkbox"/> Constipation <input type="checkbox"/> Laxative/Enema Use <input type="checkbox"/> History of Ulcers <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Belching <input type="checkbox"/> Black Stools <input type="checkbox"/> Blood in Stools <input type="checkbox"/> Stooling "Accidents" <input type="checkbox"/> Bloating <input type="checkbox"/> Hemorrhoids
GENITOURINARY	<input type="checkbox"/> NONE <input type="checkbox"/> Burning <input type="checkbox"/> Inability to Start Stream <input type="checkbox"/> Infection <input type="checkbox"/> Urgency <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Bedwetting
MALE REPRODUCTIVE	<input type="checkbox"/> NONE <input type="checkbox"/> Pain <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Circumcised <input type="checkbox"/> Impotence <input type="checkbox"/> Testicular Pain <input type="checkbox"/> History of Sexually Transmitted Diseases
FEMALE REPRODUCTIVE	<input type="checkbox"/> NONE <input type="checkbox"/> Discharge <input type="checkbox"/> Itch <input type="checkbox"/> Infection <input type="checkbox"/> Started Menstrual Cycle <input type="checkbox"/> Painful Menstrual Cramps <input type="checkbox"/> Contraceptive Use <input type="checkbox"/> Complication of Pregnancy <input type="checkbox"/> History of Sexually Transmitted Diseases <input type="checkbox"/> Childbirth <input type="checkbox"/> Abortion <input type="checkbox"/> Painful Intercourse
MUSCULOSKELETAL	<input type="checkbox"/> NONE <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Atrophy <input type="checkbox"/> Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Fracture <input type="checkbox"/> Back Injury <input type="checkbox"/> Curvature of Spine
ENDOCRINE & METABOLIC	<input type="checkbox"/> NONE <input type="checkbox"/> Heat or Cold Intolerance <input type="checkbox"/> Weight Change <input type="checkbox"/> Diabetes <input type="checkbox"/> Hair Change <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Voice Change <input type="checkbox"/> Excessive Thirst
NEUROLOGIC	<input type="checkbox"/> NONE <input type="checkbox"/> Headache <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Blindness <input type="checkbox"/> Double Vision <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremor <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tic <input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Burning Sensation <input type="checkbox"/> Lack of Coordination
PSYCHIATRIC & EMOTIONAL	<input type="checkbox"/> NONE <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Tension <input type="checkbox"/> Thoughts of Suicide <input type="checkbox"/> Emotional Instability <input type="checkbox"/> Delusions <input type="checkbox"/> Memory Loss <input type="checkbox"/> Hallucinations

THE INFORMATION ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE