

**Division of Pediatric General and Thoracic Surgery
 Patient Questionnaire Form**
PLEASE COMPLETE BOTH SIDES OF FORM

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

With whom does the patient live? _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

 No change from last visit

What is the medical reason for today's visit? _____

When was the problem first noted? _____

Does the problem seem to be worsening? _____

Who referred you to our office today? _____

List recent diagnostic tests _____

 No change from last visit
Medications:

Drug	Dose	Reason

Allergies: _____

 Are the patient's immunizations up to date? Yes No

 Has your child or any family member had reactions to anesthesia? Yes No

 Have any family members been diagnosed with malignant hyperthermia? Yes No

List past hospital admissions - when and why? _____

List surgical history – when and why? _____

 No change from last visit

Is your child growing normally? Please explain any No answers: _____

 Emotionally: Yes No Physically: Yes No Socially: Yes No

 No change from last visit
Pregnancy Information: Pregnancy Complications: _____ Birth Complications: _____

 Full Term? Yes No Premature: number of weeks _____ Birth Weight: _____ lbs. _____ oz.

 Did your newborn have a bowel movement within 24 hours after birth: Yes No

 Initial Feeding: Breast Milk Formula Brand: _____

 Tolerated Well: Yes No Spitting: Yes No Vomiting: Yes No

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Family Health History: Does any family member have a history of the following? (check all that apply)

- AIDS Asthma Bronchitis Bleeding/Clotting Disorders Cancer Colitis
 Crohn's Diabetes Down Syndrome Heart Problems Irritable Bowel
 Kidney Disease Seizures Other _____

Please complete the following:

Yes	No	Problem or Concern – <i>circle all that apply</i>	Please Describe
		weakness / irritability / behavioral issues	
		ADD / anxiety / depression / hallucinations / suicidal thoughts	
		headaches / paralysis / drooping face	
		unexplained weight loss / gain	
		nasal congestion / nose bleeds	
		eye redness / swelling / irritation	
		earaches / sore throats / strep throat / neck pain / stiffness / swelling	
		shortness of breath / dizziness / palpitations / cough / sputum / coughing up blood / wheezing	
		abdominal pain / constipation / GI bleeding / reflux / blood in stool / diarrhea / nausea / vomiting	
		frequent urination / unable to urinate / pain urinating / urinary tract infection / blood in urine	
		arm pain / leg pain / ankle swelling / numbness / tingling in arms, fingers, legs, feet	
		Itching / unexplained rashes / swelling / tenderness	
		bruise easily / bleed excessively	
		excessive thirst / hot or cold intolerance	

 No change from last visit
Social History:

Sibling(s) Name	Age	Sex

Pet(s)	Type	Number

School	Day Care	Employment

Physician Signature: _____ Date: _____ Time: _____