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

Children's Hospital of Pittsburgh of UPMC

Division of Pediatric General and Thoracic Surgery

Patient Questionnaire Form

PLEASE COMPLETE BOTH SIDES OF FORM

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 – *circle all that apply*	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:____________