



**Pediatric Surgeons
of West Michigan, P.C.**

Patient Questionnaire

Patient's Name: _____ Date of Birth: _____

Primary Care Doctor: _____ Age: _____

Why are you here today: _____

Specialists my child sees: _____

Past Medical History:

- | | | | | | |
|-------------------|--|----------------|--|-------------------------|--|
| ADHD | Yes <input type="checkbox"/> No <input type="checkbox"/> | Constipation | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Allergies | Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Migraines | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Diarrhea | Yes <input type="checkbox"/> No <input type="checkbox"/> | MRSA | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anxiety | Yes <input type="checkbox"/> No <input type="checkbox"/> | GERD | Yes <input type="checkbox"/> No <input type="checkbox"/> | Musculoskeletal problem | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> | GI Reflux | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rashes/Skin Problem | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bleeding Tendency | Yes <input type="checkbox"/> No <input type="checkbox"/> | Headaches | Yes <input type="checkbox"/> No <input type="checkbox"/> | Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood Clots | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sleep Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hypertension | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stomach Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Claustrophobia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Past Surgical History:

- | | | | | | |
|-------------------|--|------------------------|--|----------------------------|--|
| Appendectomy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Gastric Fundoplication | Yes <input type="checkbox"/> No <input type="checkbox"/> | Lung Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bowel surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> | GJ Tube Placement | Yes <input type="checkbox"/> No <input type="checkbox"/> | Nissen Fundoplication | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chest Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> | G-Tube placement | Yes <input type="checkbox"/> No <input type="checkbox"/> | NUSS | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Circumcision | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> | Orthopedic Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Ear tubes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemorrhoids | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pilonidal Cystectomy | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Esophagus Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hernia repair | Yes <input type="checkbox"/> No <input type="checkbox"/> | Testicular Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Gall Bladder | Yes <input type="checkbox"/> No <input type="checkbox"/> | Laparoscopy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tonsillectomy w/ Adenoi... | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Recent Hospitalizations:

When	Why



Family History:

	Anemia	Anesthesia problems	Bleeding problems	Cancer	Diabetes	GERD	Hernia	GI disease / disorder	HIV	Pectus carinatum	Pectus excavatum
Mother											
Father											
Sister											
Brother											
M Grandmother											
M Grandfather											
P Grandmother											
P Grandfather											

Medication History: *If you have a medication list, please have our staff make a copy.*

Medication	Dose / Strength	How Often?

Allergies: No known allergies

Yes	No	Allergen / Agent	Reaction
		Latex Allergy	
		Metal Allergy	
		Others:	

Constitution neg

Activity change

Appetite change

Crying

Dcr responsiveness

Diaphoresis

Fever

Irritability

Sleep problem

HENT neg

Ear discharge

Nosebleeds

Congestion

Rhinorrhea

Sneezing

Drooling

Hoarse Voice

Trouble swallowing

Eyes neg

Eye discharge

Eye redness

Light Sensitivity

Visual disturbance

Respiratory neg

Cough

Wheezing

Stridor

Apnea

Choking

Cardiovascular neg

Cyanosis

Fatigue with feeds

Leg swelling

Sweating w/ feeds

GI neg

Reflux

Vomiting

Constipation

Diarrhea

Rectal bleeding

Blood in stool

MS neg

Extremity weakness

Joint swelling

Neurological neg

Facial asymmetry

LOC

Seizures

Tremors

Endo/Heme/Aller neg

Adenopathy

Bruises/blds easily

Env allergies

Polydipsia

Skin neg

Itching

Color change

Pallor

New spots

Changed spots

Rash

Wound

Please circle (+) for any symptom that currently applies to your child and (-) for any symptom that currently does not apply to your child.

Please write additional comments regarding (+) responses.



Ages 1-5

Constitution neg

Activity change

Appetite change

Chills

Crying

Diaphoresis

Fatigue

Fever

Irritability

Unexpectd wt chngs

HENT neg

Headaches

Ear discharge

Hearing loss

Ear pain

Nosebleeds

Congestion

Rhinorrhea

Sneezing

Drooling

Sore throat

Hoarse voice

Trouble swallowing

Eyes neg

Eye discharge

Eye itching

Eye pain

Eye redness

Light sensitivity

Visual disturbance

Respiratory neg

Cough

Wheezing

Shortness of breath

Stridor

Snoring

Apnea

Choking

Cardiovascular neg

Chest pain

Cyanosis

Leg swelling

GI neg

Reflux

Nausea

Vomiting

Abdominal pain

Constipation

Diarrhea

Rectal pain

Rectal bleeding

Blood in stool

GU neg

Difficulty urinating

Dysuria

Enuresis

Flank pain

Frequency

Hematuria

Urgency

Polyuria

Urine decreased

MS neg

Neck pain

Back pain

Joint pain

Joint swelling

Muscle pain

Gait problem

Neurological neg

Facial asymmetry

Focal weakness

Speech difficulty

LOC

Seizures

Tremors

Endo/Heme/Alter neg

Adenopathy

Bruises/blds easily

Env allergies

Polydipsia

Psychiatric neg

Agitation

Behavior problem

Sleep disturbance

Self-injury

Hallucinations

Hyperactive

Skin neg

Itching

Color change

Pallor

New spots

Changed spots

Rash

Wound

Please circle (+) for any symptom that currently applies to your child and (-) for any symptom that currently does not apply to your child.

Please write additional comments regarding (+) responses.

Constitution <input type="checkbox"/> neg	Eyes <input type="checkbox"/> neg	GI <input type="checkbox"/> neg	MS <input type="checkbox"/> neg	Behavioral <input type="checkbox"/> neg
<input type="checkbox"/> Activity change	<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Depression
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Eye itching	<input type="checkbox"/> Nausea	<input type="checkbox"/> Back pain	<input type="checkbox"/> Suicidal ideas
<input type="checkbox"/> Chills	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Diaphoresis	<input type="checkbox"/> Eye redness	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Self-injury
<input type="checkbox"/> Fever	<input type="checkbox"/> Visual disturbance	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Gait problem	<input type="checkbox"/> Sleep disturbance
<input type="checkbox"/> Irritability	Respiratory <input type="checkbox"/> neg	<input type="checkbox"/> Rectal pain	Neurological <input type="checkbox"/> neg	<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Unexpectd wt change	<input type="checkbox"/> Cough	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Behavior problem
HEENT <input type="checkbox"/> neg	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Decr concentration
<input type="checkbox"/> Headaches	<input type="checkbox"/> Shortness of breath	GU <input type="checkbox"/> neg	<input type="checkbox"/> Speech difficulty	Skin <input type="checkbox"/> neg
<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> LOC	<input type="checkbox"/> Itching
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Stridor	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Seizures	<input type="checkbox"/> Color change
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Snoring	<input type="checkbox"/> Enuresis	<input type="checkbox"/> Tremors	<input type="checkbox"/> Pallor
<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Choking	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> New spots
<input type="checkbox"/> Nosebleeds	Cardiovascular <input type="checkbox"/> neg	<input type="checkbox"/> Frequency	<input type="checkbox"/> Weakness	<input type="checkbox"/> Changed spots
<input type="checkbox"/> Congestion	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hematuria	Endo/Heme/Aller <input type="checkbox"/> neg	<input type="checkbox"/> Rash
<input type="checkbox"/> Rhinorhea	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urgency	<input type="checkbox"/> Adenopathy	<input type="checkbox"/> Wound
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Polyuria	<input type="checkbox"/> Bruises/blds easy	
<input type="checkbox"/> Drooling		<input type="checkbox"/> Menstrual problem	<input type="checkbox"/> Env allergies	
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Polydipsia	
<input type="checkbox"/> Hoarse voice		<input type="checkbox"/> Vaginal bleeding		
<input type="checkbox"/> Trouble swallowing		<input type="checkbox"/> Vaginal discharge		
		<input type="checkbox"/> Vaginal pain		

Please circle (+) for any symptom that currently applies to your child and (-) for any symptom that currently does not apply to your child.

Please write additional comments regarding (+) responses.

<input type="checkbox"/> Constitution <input type="checkbox"/> neg <input type="checkbox"/> Activity change <input type="checkbox"/> <input type="checkbox"/> Appetite change <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Diaphoresis <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Unexpctd wt chnge <input type="checkbox"/>	<input type="checkbox"/> Eyes <input type="checkbox"/> neg <input type="checkbox"/> Eye discharge <input type="checkbox"/> <input type="checkbox"/> Eye itching <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> Eye redness <input type="checkbox"/> <input type="checkbox"/> Light sensitivity <input type="checkbox"/> <input type="checkbox"/> Visual disturbance <input type="checkbox"/> <input type="checkbox"/> Respiratory <input type="checkbox"/> neg <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/> Chest tightness <input type="checkbox"/> <input type="checkbox"/> Snoring <input type="checkbox"/> <input type="checkbox"/> Choking <input type="checkbox"/> <input type="checkbox"/> Sputum production <input type="checkbox"/> <input type="checkbox"/> Cardiovascular <input type="checkbox"/> neg <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Orthopnea <input type="checkbox"/> <input type="checkbox"/> Claudication <input type="checkbox"/> <input type="checkbox"/> Leg swelling <input type="checkbox"/> <input type="checkbox"/> PND <input type="checkbox"/>	<input type="checkbox"/> GI <input type="checkbox"/> neg <input type="checkbox"/> Heartburn <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Fecal incontinence <input type="checkbox"/> <input type="checkbox"/> Rectal pain <input type="checkbox"/> <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> <input type="checkbox"/> Blood in stool <input type="checkbox"/> <input type="checkbox"/> GU <input type="checkbox"/> neg <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> <input type="checkbox"/> Dysuria <input type="checkbox"/> <input type="checkbox"/> Incontinence <input type="checkbox"/> <input type="checkbox"/> Flank pain <input type="checkbox"/> <input type="checkbox"/> Frequency <input type="checkbox"/> <input type="checkbox"/> Hematuria <input type="checkbox"/> <input type="checkbox"/> Urgency <input type="checkbox"/> <input type="checkbox"/> Polyuria <input type="checkbox"/> <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/>	<input type="checkbox"/> MS <input type="checkbox"/> neg <input type="checkbox"/> Neck pain <input type="checkbox"/> <input type="checkbox"/> Back pain <input type="checkbox"/> <input type="checkbox"/> Joint pain <input type="checkbox"/> <input type="checkbox"/> Joint swelling <input type="checkbox"/> <input type="checkbox"/> Muscle pain <input type="checkbox"/> <input type="checkbox"/> Gait problem <input type="checkbox"/> <input type="checkbox"/> Falls <input type="checkbox"/> <input type="checkbox"/> Neurological <input type="checkbox"/> neg <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Light-headedness <input type="checkbox"/> <input type="checkbox"/> Speech difficulty <input type="checkbox"/> <input type="checkbox"/> LOC <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Tremors <input type="checkbox"/> <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> <input type="checkbox"/> Weakness <input type="checkbox"/> <input type="checkbox"/> Endo/Hema/Alter <input type="checkbox"/> neg <input type="checkbox"/> Adenopathy <input type="checkbox"/> <input type="checkbox"/> Bruises/blds easily <input type="checkbox"/> <input type="checkbox"/> Env allergies <input type="checkbox"/> <input type="checkbox"/> Polydipsia <input type="checkbox"/>	<input type="checkbox"/> Psychiatric <input type="checkbox"/> neg <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Suicidal ideas <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Hallucinations <input type="checkbox"/> <input type="checkbox"/> Self-injury <input type="checkbox"/> <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> <input type="checkbox"/> Hyperactive <input type="checkbox"/> <input type="checkbox"/> Behavior problem <input type="checkbox"/> <input type="checkbox"/> Decr concentration <input type="checkbox"/> <input type="checkbox"/> Skin <input type="checkbox"/> neg <input type="checkbox"/> Itching <input type="checkbox"/> <input type="checkbox"/> Color change <input type="checkbox"/> <input type="checkbox"/> Pallor <input type="checkbox"/> <input type="checkbox"/> New spots <input type="checkbox"/> <input type="checkbox"/> Changed spots <input type="checkbox"/> <input type="checkbox"/> Rash <input type="checkbox"/> <input type="checkbox"/> Wound <input type="checkbox"/> <input type="checkbox"/> Nail changes <input type="checkbox"/> <input type="checkbox"/> Hair changes <input type="checkbox"/>
---	--	---	---	---

Please circle (+) for any symptom that currently applies to your child and (-) for any symptom that currently does not apply to your child.

Please write additional comments regarding (+) responses.