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 No	Constipation	Yes No	Liver disease	Yes No
Allergies	Yes No	Diabetes	Yes No	Migraines	Yes No
Anemia	Yes No	Diarrhea	Yes No	MRSA	Yes No
Anxiety	Yes No	GERD	Yes No	Musculoskeletal problem	Yes No
Asthma	Yes No	GI Reflux	Yes No	Rashes/Skin Problem	Yes No
Bleeding Tendency	Yes No	Headaches	Yes No	Seizures	Yes No
Blood Clots	Yes No	Heart problems	Yes No	Sleep Trouble	Yes No
Cancer	Yes No	Hypertension	Yes No	Stomach Problems	Yes No
Claustrophobia	Yes No	Kidney disease	Yes No	Thyroid disease	Yes No

Past Surgical History:

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

Recent Hospitalizations:

When	Why

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Patient Questionnaire

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:	

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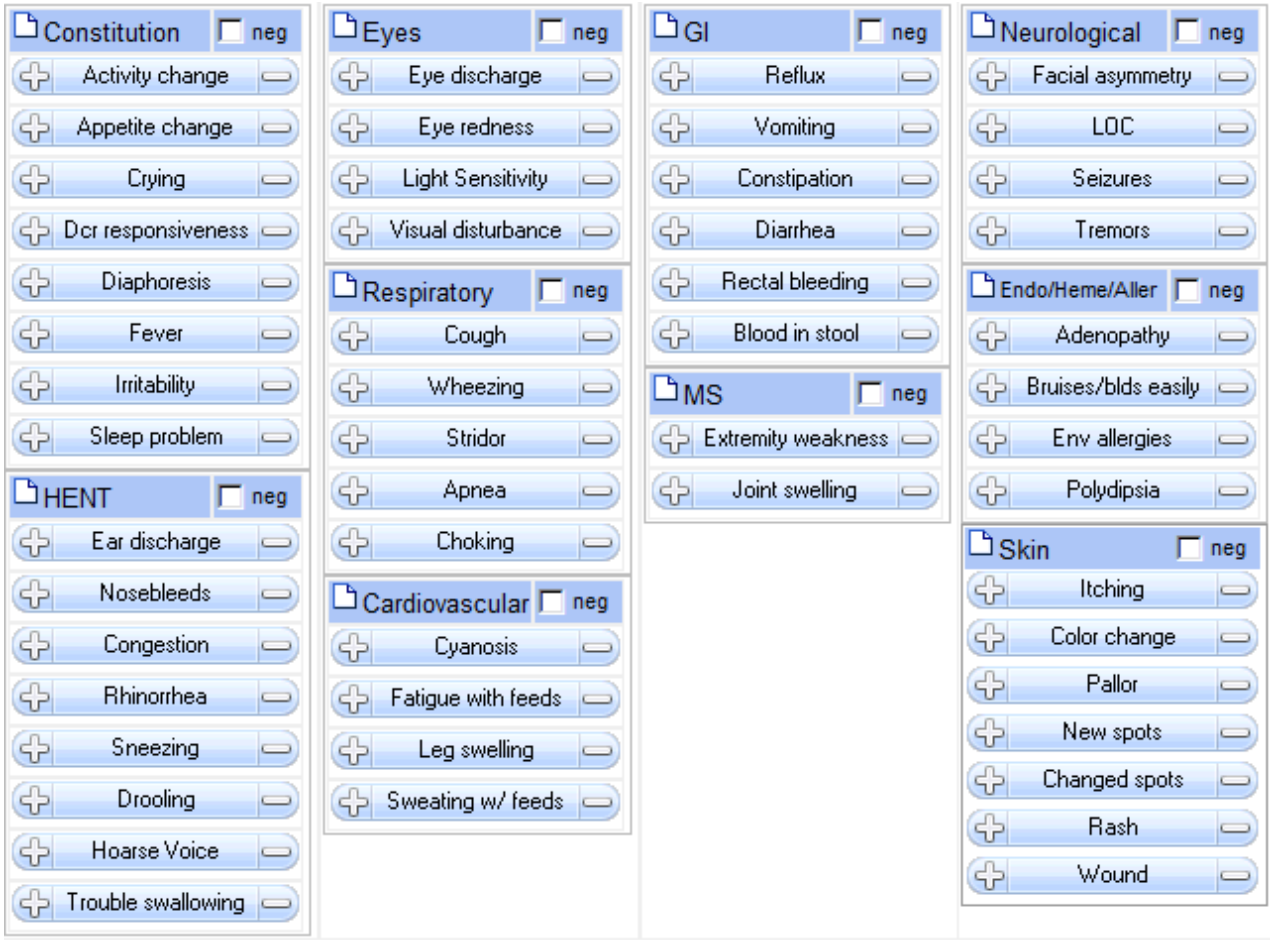
Review of Systems

Age 0-1



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.

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Review of Systems

Ages 1-5

Constitution neg
- Activity change
- Appetite change
- Chills
- Crying
- Diaphoresis
- Fatigue
- Fever
- Irritability
- Unexpctd wt chnge

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/Aller 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

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Please write additional comments regarding (+) responses.

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Review of Systems

Ages 5-13

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.

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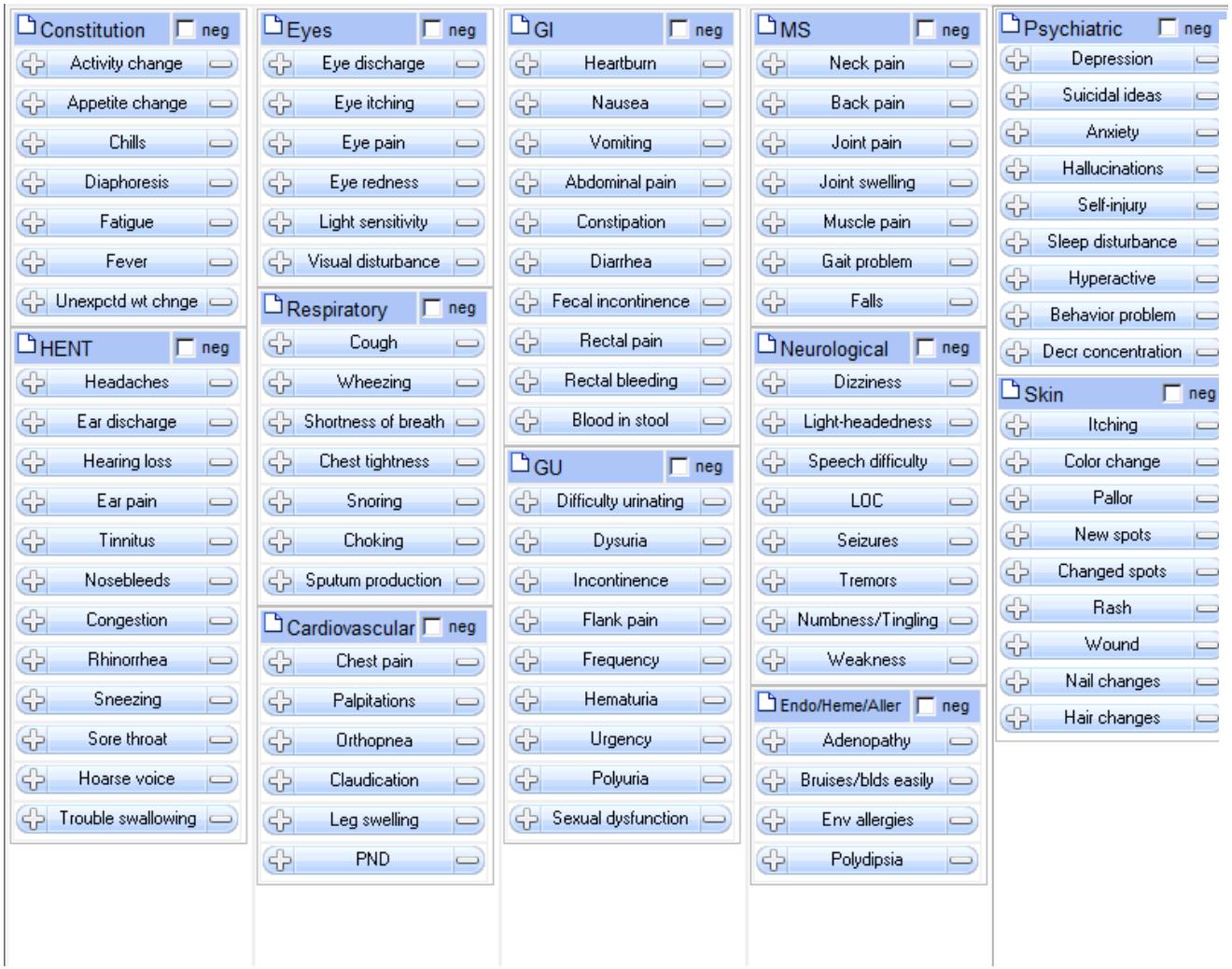
Review of Systems

Ages 13+



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Please write additional comments regarding (+) responses.