



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:	

Review of Systems

Age 0-1

<p>Constitution <input type="checkbox"/> neg</p> <p>+ Activity change -</p> <p>+ Appetite change -</p> <p>+ Crying -</p> <p>+ Dcr responsiveness -</p> <p>+ Diaphoresis -</p> <p>+ Fever -</p> <p>+ Irritability -</p> <p>+ Sleep problem -</p>	<p>Eyes <input type="checkbox"/> neg</p> <p>+ Eye discharge -</p> <p>+ Eye redness -</p> <p>+ Light Sensitivity -</p> <p>+ Visual disturbance -</p>	<p>GI <input type="checkbox"/> neg</p> <p>+ Reflux -</p> <p>+ Vomiting -</p> <p>+ Constipation -</p> <p>+ Diarrhea -</p> <p>+ Rectal bleeding -</p> <p>+ Blood in stool -</p>	<p>Neurological <input type="checkbox"/> neg</p> <p>+ Facial asymmetry -</p> <p>+ LOC -</p> <p>+ Seizures -</p> <p>+ Tremors -</p>
<p>HENT <input type="checkbox"/> neg</p> <p>+ Ear discharge -</p> <p>+ Nosebleeds -</p> <p>+ Congestion -</p> <p>+ Rhinorrhea -</p> <p>+ Sneezing -</p> <p>+ Drooling -</p> <p>+ Hoarse Voice -</p> <p>+ Trouble swallowing -</p>	<p>Respiratory <input type="checkbox"/> neg</p> <p>+ Cough -</p> <p>+ Wheezing -</p> <p>+ Stridor -</p> <p>+ Apnea -</p> <p>+ Choking -</p>	<p>MS <input type="checkbox"/> neg</p> <p>+ Extremity weakness -</p> <p>+ Joint swelling -</p>	<p>Endo/Heme/Aller <input type="checkbox"/> neg</p> <p>+ Adenopathy -</p> <p>+ Bruises/blds easily -</p> <p>+ Env allergies -</p> <p>+ Polydipsia -</p>
	<p>Cardiovascular <input type="checkbox"/> neg</p> <p>+ Cyanosis -</p> <p>+ Fatigue with feeds -</p> <p>+ Leg swelling -</p> <p>+ Sweating w/ feeds -</p>		<p>Skin <input type="checkbox"/> neg</p> <p>+ Itching -</p> <p>+ Color change -</p> <p>+ Pallor -</p> <p>+ New spots -</p> <p>+ Changed spots -</p> <p>+ Rash -</p> <p>+ Wound -</p>

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.

<p>Constitution <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Activity change <input type="checkbox"/></p> <p><input type="checkbox"/> Appetite change <input type="checkbox"/></p> <p><input type="checkbox"/> Chills <input type="checkbox"/></p> <p><input type="checkbox"/> Crying <input type="checkbox"/></p> <p><input type="checkbox"/> Diaphoresis <input type="checkbox"/></p> <p><input type="checkbox"/> Fatigue <input type="checkbox"/></p> <p><input type="checkbox"/> Fever <input type="checkbox"/></p> <p><input type="checkbox"/> Irritability <input type="checkbox"/></p> <p><input type="checkbox"/> Unexpctd wt chnge <input type="checkbox"/></p>	<p>Eyes <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Eye discharge <input type="checkbox"/></p> <p><input type="checkbox"/> Eye itching <input type="checkbox"/></p> <p><input type="checkbox"/> Eye pain <input type="checkbox"/></p> <p><input type="checkbox"/> Eye redness <input type="checkbox"/></p> <p><input type="checkbox"/> Light sensitivity <input type="checkbox"/></p> <p><input type="checkbox"/> Visual disturbance <input type="checkbox"/></p> <p>Respiratory <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Cough <input type="checkbox"/></p> <p><input type="checkbox"/> Wheezing <input type="checkbox"/></p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/></p> <p><input type="checkbox"/> Stridor <input type="checkbox"/></p> <p><input type="checkbox"/> Snoring <input type="checkbox"/></p> <p><input type="checkbox"/> Apnea <input type="checkbox"/></p> <p><input type="checkbox"/> Choking <input type="checkbox"/></p> <p>Cardiovascular <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/></p> <p><input type="checkbox"/> Cyanosis <input type="checkbox"/></p> <p><input type="checkbox"/> Leg swelling <input type="checkbox"/></p>	<p>GI <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Reflux <input 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<input type="checkbox"/></p> <p><input type="checkbox"/> Urgency <input type="checkbox"/></p> <p><input type="checkbox"/> Polyuria <input type="checkbox"/></p> <p><input type="checkbox"/> Urine decreased <input type="checkbox"/></p>	<p>MS <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Neck pain <input type="checkbox"/></p> <p><input type="checkbox"/> Back pain <input type="checkbox"/></p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/></p> <p><input type="checkbox"/> Joint swelling <input type="checkbox"/></p> <p><input type="checkbox"/> Muscle pain <input type="checkbox"/></p> <p><input type="checkbox"/> Gait problem <input type="checkbox"/></p> <p>Neurological <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Facial asymmetry <input type="checkbox"/></p> <p><input type="checkbox"/> Focal weakness <input type="checkbox"/></p> <p><input type="checkbox"/> Speech difficulty <input type="checkbox"/></p> <p><input type="checkbox"/> LOC <input type="checkbox"/></p> <p><input type="checkbox"/> Seizures <input type="checkbox"/></p> <p><input type="checkbox"/> Tremors <input type="checkbox"/></p> <p>Endo/Heme/Aller <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Adenopathy <input type="checkbox"/></p> <p><input type="checkbox"/> Bruises/blds easily <input type="checkbox"/></p> <p><input type="checkbox"/> Env allergies <input type="checkbox"/></p> <p><input type="checkbox"/> Polydipsia <input type="checkbox"/></p>	<p>Psychiatric <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Agitation <input type="checkbox"/></p> <p><input type="checkbox"/> Behavior problem <input type="checkbox"/></p> <p><input type="checkbox"/> Sleep disturbance <input type="checkbox"/></p> <p><input type="checkbox"/> Self-injury <input type="checkbox"/></p> <p><input type="checkbox"/> Hallucinations <input type="checkbox"/></p> <p><input type="checkbox"/> Hyperactive <input type="checkbox"/></p> <p>Skin <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Itching <input type="checkbox"/></p> <p><input type="checkbox"/> Color change <input type="checkbox"/></p> <p><input type="checkbox"/> Pallor <input type="checkbox"/></p> <p><input type="checkbox"/> New spots <input type="checkbox"/></p> <p><input type="checkbox"/> Changed spots <input type="checkbox"/></p> <p><input type="checkbox"/> Rash <input type="checkbox"/></p> <p><input type="checkbox"/> Wound <input type="checkbox"/></p>
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	<p>Cardiovascular <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/></p> <p><input type="checkbox"/> Palpitations <input type="checkbox"/></p> <p><input type="checkbox"/> Orthopnea <input type="checkbox"/></p> <p><input type="checkbox"/> Claudication <input type="checkbox"/></p> <p><input type="checkbox"/> Leg swelling <input type="checkbox"/></p> <p><input type="checkbox"/> PND <input type="checkbox"/></p>		<p>Endo/Heme/Aller <input type="checkbox"/> neg</p> <p><input type="checkbox"/> Adenopathy <input type="checkbox"/></p> <p><input type="checkbox"/> Bruises/blds easily <input type="checkbox"/></p> <p><input type="checkbox"/> Env allergies <input type="checkbox"/></p> <p><input type="checkbox"/> Polydipsia <input type="checkbox"/></p>	

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