Children's Surgical Associates

Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: _____ Date: _____
DOB: _____ Age: _____ Referring Doctor: _____
Primary Doctor: _____ Patient best contact#: _____

Reason for Visit: _____

A. PAST MEDICAL HISTORY

1. **Birth History**: Birth Weight: _____ Length: _____ Full Term / Premature (circle one)
Pregnancy problems or infections: _____

Labor/Delivery: Vaginal / C-section (circle one) Describe any problems:

Problems in the Nursery/ 1st month of life: _____

2. List any **medical problems** that your child has

List all **medications** (include over the counter and herbal therapies).

3. List any **hospitalizations** that your child has had. Include his/her age, where hospitalized, and the reason for the hospitalization.

Drug Allergies: _____

Are immunizations up to date?
☐ Yes ☐ No

4. List any **surgeries/procedures** with the approximate dates performed that your child has had. Include those done as an outpatient: _____

B. FAMILY HISTORY

1. Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

☐ Skin boils or staph infections	☐ Immunodeficiencies	☐ Bleeding Problems	☐ Kidney Disease
☐ Colon Cancer	☐ Liver & Gallbladder Disease	☐ Blood Disorders	☐ Lipids /High Cholesterol
☐ Unexplained fevers	☐ Tuberculosis	☐ Diabetes	☐ Lung Problems
☐ Crohn's Disease	☐ Ulcerative Colitis	☐ Headaches	☐ Amyloidosis
☐ Cystic Fibrosis	☐ Cold sores	☐ Heart Disease	☐ Fam. Mediterranean Fever
☐ Prolonged or recurrent infections	☐ Allergic Disease	☐ Hypertension	☐ HIV
☐ Gastrointestinal Disorder	☐ Sickle cell disease	☐ Infant/Child Death	

2. Is there any other disease/illness that runs in the family? _____

C. SOCIAL HISTORY:

1. Who lives in the same household with the patient?: _____
2. Is your child in daycare? ☐ Yes ☐ No

3. **School History**:
A) Grade in school: _____

Children's Surgical Associates
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Last Name: _____ **First Name:**_____ **Date:** _____/_____/_____

General
- O Feeling Well
- O Fatigue
- O Weight Gain
- O Weight Loss
- O Dietary Changes
- O Fever
- O Chills
- O Night Sweats
- O Lethargy
- O Excessive Crying

Skin
- O Rash
- O Birthmark
- O Bruising
- O Jaundice
- O Change in Mole
- O Change in Incision
- O Swelling
- O Abscess

HEENT
- O Headache
- O Eye Redness
- O Visual Disturbances
- O Hearing Loss
- O Ear Infection
- O Nose Bleed
- O Bleeding Gums
- O Nasal Congestion
- O Sinus Pain
- O Hoarseness
- O Sore Throat

Neck
- O Neck Mass
- O Neck Pain
- O Neck Stiffness
- O Swollen Glands
- O Abscess

Respiratory
- O Cough
- O Snoring
- O Difficulty Breathing
- O Sputum Production
- O Wheezing
- O Coughing up blood

Breast
- O Breast Mass
- O Breast Pain
- O Nipple Discharge
- O Skin Changes

Cardiovascular
- O Heart Murmur
- O Congenital Anomaly
- O Irregular Heart Beat
- O Abnormal Blood Pressure
- O Palpitations
- O Rapid Heart Rate
- O Shortness of Breath

Gastrointestinal
- O Nausea
- O Vomiting
- O Diarrhea
- O Constipation
- O Difficulty Swallowing
- O Heartburn
- O Vomiting Blood
- O Indigestion
- O Abdominal Pain
- O Gas
- O Change in Bowel Habits
- O Black, Tarry Stools
- O Jaundice
- O Rectal Bleeding
- O Soiling

Male Genitourinary
- O Groin Bulge
- O Testicular Mass
- O Testicular Pain
- O Blood in Urine

Female Genitourinary
- O Frequent Urination
- O Burning Urination
- O Urine Infection
- O Amenorrhea
- O Vaginal Discharge
- O Groin Bulge

Hematology
- O Abnormal Bleeding
- O Easy Bruising
- O Anemia
- O Blood Clots
- O Nose Bleed
- O Enlarged Nodes
- O Petechiae

Endocrine
- O Appetite Changes
- O Hair Changes
- O Heat Intolerance
- O Thyroid Problems
- O Excessive Thirst
- O Frequent Urination

Parent Signature:_____