Pediatric Surgical Services, Inc.

New Patient Medical History Questionnaire

To assist us in caring for your child, please complete the following questionnaire

Why are you here today?
What has been done thus far for this problem? (i.e. lab tests, X-rays, ultrasounds, MRT, CT, VCUG, medications)

HISTORY OF PATIENT'S BIRTH				
Mother's pregnancy with patient was:	Full Term		Ended early, @ _____ wks. Gestation	
Delivery was:	Vaginal		Scheduled C-section	Emergency C-Section
Complicated pregnancy or delivery?	No	Yes	Please explain:	
Medications taken while pregnant?	No	Yes	What?	

PAST MEDICAL HISTORY					
Hospitalizations	No	Yes	When?	Where?	Why?
Surgeries	No	Yes	When?	Where?	Why?
Blood Transfusions	No	Yes	When?	Where?	
Contagious Disease	No	Yes	What?	Where?	
Psychological Care	No	Yes	When?	Where?	Why?
Is child still receiving psychological care?	No	Yes	By whom?		

CHILDS FAMILY HISTORY

Have any blood-related patient, sibling, grandparent, aunt, uncle or cousin of the patient had problems concerning:

Anesthetic	No	Yes	Who?	Deceased?	No	Yes	Age:
Asthma	No	Yes	Who?	Deceased?	No	Yes	Age:
Bleeding	No	Yes	Who?	Deceased?	No	Yes	Age:
Cancer	No	Yes	Who?	Deceased?	No	Yes	Age:
Developmental delays	No	Yes	Who?	Deceased?	No	Yes	Age:
Diabetes	No	Yes	Who?	Deceased?	No	Yes	Age:
Heart Disease	No	Yes	Who?	Deceased?	No	Yes	Age:
Liver or kidney disease	No	Yes	Who?	Deceased?	No	Yes	Age:
Seizures	No	Yes	Who?	Deceased?	No	Yes	Age:
Tuberculosis	No	Yes	Who?	Deceased?	No	Yes	Age:
Bedwetting	No	Yes	Who?	Deceased?	No	Yes	Age:
Other							

SOCIAL HISTORY					
Patient's parents are:	Married	Unmarried	Divorced	Separated	Widowed (one parent is deceased)
Who does patient live with?					
Attends school?	No	Yes	Grade:	School:	
Other					

CURRENT MEDICATIONS

Medication and dose	Homeopathic or Natural Remedies/vits
1.	1.
2.	2.
3.	3.
4.	4.

REVIEW OF SYSTEMS

Has the patient had any problems with:

HEENT (head/eyes/ears/throat)			**Musculoskeletal (muscle and bone)**		
Headaches	No	Yes	Muscles	No	Yes
Eyes	No	Yes	Bones	No	Yes
Ears	No	Yes	Arms	No	Yes
Nose	No	Yes	Legs	No	Yes
Swollen glands	No	Yes	Hips	No	Yes
Sinus problems	No	Yes	Back	No	Yes
Pulmonary (lungs)			Feet	No	Yes
Asthma/Wheezing	No	Yes	**Hematologic/Lymph (blood)**		
Persistent Cough	No	Yes	Clotting problems	No	Yes
Shortness of Breath	No	Yes	Bleeding problems	No	Yes
Cardiac (heart)	No	Yes	Bruising easily	No	Yes
Heart defect(s)	No	Yes	**Neurologic (nervous system)**		
Skin turning blue	No	Yes	Head Injury	No	Yes
Heart murmur(s)	No	Yes	Seizures	No	Yes
Palpitations	No	Yes	**Psychological**	No	Yes
GI (digestive system)			Depression	No	Yes
Stomach	No	Yes	Anxiety/nervousness	No	Yes
Constipation	No	Yes	Sleep disorder	No	Yes
Diarrhea	No	Yes	**Integumentary**	No	Yes
Nausea/Vomiting	No	Yes	Poor wound healing	No	Yes
			Rashes		
Allergies	No	Yes	To what?		
Endocrine (hormonal system)					
Excessive appetite	No	Yes	Weight problem	No	Yes
Excessive thirst	No	Yes	Cold/heat intolerance	No	Yes

_____ _____

Provider Signature Date

Date Reviewed	Prov. Initials		Date Reviewed	Prov. Initials		Date Reviewed	Prov. Initials		Date Reviewed	Prov. Initials

Note: Changes to ROS, medical, family and social history is documented in progress note.