# 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.*