CSSG Pt Questionnaii

8 9 9 5 4

CHILDREN'S SURGICAL SPECIALTY GROUP
PATIENT QUESTIONNAIRE

TODAY'S DATE_____

PATIENT NAME _____
First Name Middle Name Last Name

DATE OF BIRTH_____ **AGE**_____ years, _____ months

HOME PH _____ **CELL PH** _____

E-MAIL ADDRESS _____

PRIMARY CARE PHYSICIAN (PCP) _____

PCP'S ADDRESS _____
Street Address City State Zip

PCP'S PHONE NUMBER (_____) _____

What is the problem that brings your child to the doctor's office today?_____
_____
_____

Did another physician other than your PCP refer you? ❑ Yes ❑ No If yes, please list below:

_____
First Name Last Name Street Address City State Zip Phone

Are there other physicians involved in your child's care? ❑ Yes ❑ No If yes, please list their name(s)
_____

CURRENT MEDICAL PROBLEMS: _____
_____
_____

CURRENT MEDICATIONS:
Drug_____ Dose_____ Frequency_____
Drug_____ Dose_____ Frequency_____
Drug_____ Dose_____ Frequency_____
Drug_____ Dose_____ Frequency_____

ALLERGIES TO FOODS? ❑ Yes ❑ No If yes, please list_____
_____

ALLERGIES TO MEDICATIONS? ❑ Yes ❑ No If yes, please list_____
_____

ALLERGIES TO METAL OBJECTS? ❑ Yes ❑ No If yes, please list_____
_____

ALLERGIES TO LATEX? ❑ Yes ❑ No **ARE IMMUNIZATIONS UP TO DATE?** ❑ Yes ❑ No

PRIOR ILLNESSES? ❑ Yes ❑ No If yes, please state illness, dates, treatment and duration:_____
_____
_____

PATIENT NAME_____ **DOB:**_____

PRIOR INJURIES? ❑ Yes ❑ No If yes, please state type of injury, date and treatment:_____

_____

_____

PRIOR SURGERY? ❑ Yes ❑ No If yes, please state type of surgery and date:_____

_____

PRIOR HOSPITALIZATIONS? ❑ Yes ❑ No If yes, please state dates, reasons and location:_____

_____

PRIOR X-RAYS? ❑ Yes ❑ No If yes, please state type of x-ray and date: _____

_____

ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD'S MEDICAL HISTORY? _____

WAS CHILD FULL TERM? ❑ Yes ❑ No If no, gestational age:_____

MODE OF DELIVERY: ❑ VAGINAL ❑ C-SECTION **POSITION**: ❑ Vertex (head first) ❑ Breech (feet first)

WEIGHT AT BIRTH: _____pounds, _____ounces **LENGTH AT BIRTH:** _____inches

PRENATAL ISSUES? _____

FAMILY HISTORY

ARE BOTH PARENTS ALIVE AND WELL? ❑ Yes ❑ No If no, please state the deceased parent and the cause of death:_____

HOW MANY BROTHERS AND SISTERS DOES THE PATIENT HAVE? _____Brothers _____Sisters

ARE THEY ALIVE AND WELL? ❑ Yes ❑ No If no, please state the illness or cause of death: _____

_____

IS THERE ANY PERTINENT FAMILY MEDICAL HISTORY? ❑ Yes ❑ No If yes, please provide details:

_____

GENETIC DISORDERS: ❑ Yes ❑ No **BLEEDING DISORDERS:** ❑ Yes ❑ No

SOCIAL HISTORY

WITH WHOM DOES THE PATIENT CURRENTLY RESIDE? _____

SCHOOL: _____ **GRADE:** _____

IS THE PATIENT ACTIVE IN SPORTS OR OTHER ORGANIZED ACTIVITIES? ❑ Yes ❑ No
If yes, please state the sport or type of activity_____

HAS THE PATIENT HAD A HISTORY OF DRUG, ALCOHOL AND/OR TOBACCO USE? ❑ Yes ❑ No
If yes, please state the type and duration_____

IS THE PATIENT SEXUALLY ACTIVE? ❑ Yes ❑ No If yes, please state for how long _____

ANY ADDITIONAL RELEVANT SOCIAL FACTORS YOU WOULD LIKE US TO KNOW ABOUT? _____

_____

Developmental Milestones :

ROLLING OVER: □ Yes, age:_____	□ NO	CRAWLING: □ Yes, age:_____	□ NO
SITTING UP: □ Yes, list age:_____	□ NO	WALKING: □ Yes, list age:_____	□ NO

PATIENT NAME_____ **DOB:**_____

Review of Systems

SYSTEM	PLEASE CHECK ALL THAT APPLY
GENERAL	❑ **NONE** ❑ Fatigue ❑ Fever ❑ Chills ❑ Sweats ❑ Change in Appetite ❑ Fainting ❑ Change in Sleep Habits ❑ Weight Loss ❑ Weight Gain ❑ Bleeding Problems
HEAD	❑ **NONE** ❑ Headaches ❑ Recent Trauma
EYES	❑ **NONE** ❑ Decreased Vision ❑ Pain ❑ Itch ❑ Dryness ❑ Redness ❑ Infection ❑ Glaucoma ❑ Double Vision ❑ Glasses ❑ Contact Lenses
EARS	❑ **NONE** ❑ Decreased Hearing ❑ Deafness ❑ Discharge ❑ Pain ❑ Ringing ❑ Dizziness
NOSE & SINUSES	❑ **NONE** ❑ Decreased Sense of Smell ❑ Bleeding ❑ Dryness ❑ Pain❑ Discharge ❑ Obstruction ❑ Sinusitis ❑ Seasonal Allergies
THROAT & MOUTH	❑ **NONE** ❑ Sore Throat ❑ Pain ❑ Infection ❑ Sore Tongue ❑ Ulcers ❑ Blisters ❑ Lip Lesions ❑ Canker Sores ❑ Difficulty Swallowing ❑ Hoarseness ❑ Tonsillitis ❑ Problems with Teeth
NECK	❑ **NONE** ❑ Stiffness ❑ Decreased Motion ❑ Pain ❑ Lumps ❑ Swollen Glands
BREASTS	❑ **NONE** ❑ Discharge ❑ Bleeding ❑ Retraction ❑ Tenderness ❑ Size
SKIN	❑ **NONE** ❑ Rash ❑ Itch ❑ Color Change ❑ Moles/Changes ❑ Infections ❑ Hair/Changes ❑ Nails/Changes ❑ Tumors ❑ Sores ❑ Hives
RESPIRATORY	❑ **NONE** ❑ Cough ❑ Chest Pain ❑ Wheezing ❑ Asthma ❑ Pneumonia ❑ Sputum (Color/Frequency) ❑ Recurrent Infection ❑ Exposure to Tuberculosis ❑ Cyanosis (bluish tint to skin, lips, nails) ❑ Shortness of Breath on Exercise
CARDIOVASCULAR	❑ **NONE** ❑ Chest Pain ❑ Murmur ❑ Palpitations ❑ Shortness of Breath ❑ Difficulty Breathing ❑ Fainting ❑ Phlebitis ❑ Varicose Veins
LYMPHATIC	❑ **NONE** ❑ Anemia ❑ Bleeding ❑ Malignancy ❑ Swollen Lymph Nodes ❑ Transfusions
GASTROINTESTINAL	❑ **NONE** ❑ Nausea ❑ Vomiting ❑ Vomiting Blood ❑ Diarrhea ❑ Heartburn ❑ Food Intolerance ❑ Change in Bowel Habits ❑ Hernia ❑ Constipation ❑ Laxative/Enema Use ❑ History of Ulcers ❑ Abdominal Pain ❑ Belching ❑ Black Stools ❑ Blood in Stools ❑ Stooling "Accidents" ❑ Bloating ❑ Hemorrhoids ❑ Nutritional Concerns_____
GENITOURINARY	❑ **NONE** ❑ Burning ❑ Inability to Start Stream ❑ Infection ❑ Urgency ❑ Blood in Urine ❑ Incontinence ❑ Kidney Stones ❑ Bedwetting ❑ Daytime Urinary Leakage ❑ Urinating Less Often ❑ Urinating More Often ❑ Toilet Trained, at what age _____
MALE REPRODUCTIVE	❑ **NONE** ❑ Pain ❑ Skin Lesions ❑ Circumcised ❑ Impotence ❑ Testicular Pain ❑ History of Sexually Transmitted Diseases
FEMALE REPRODUCTIVE	❑ **NONE** ❑ Discharge ❑ Itch ❑ Infection ❑ Started Menstrual Cycle ❑ Painful Menstrual Cramps ❑ Contraceptive Use ❑ Complication of Pregnancy ❑ History of Sexually Transmitted Diseases ❑ Childbirth ❑ Abortion ❑ Painful Intercourse
MUSCULOSKELETAL	❑ **NONE** ❑ Muscle Cramps ❑ Pain ❑ Weakness ❑ Atrophy ❑ Swelling ❑ Joint Pain ❑ Fracture ❑ Back Injury ❑ Curvature of Spine
ENDOCRINE & METABOLIC	❑ **NONE** ❑ Heat or Cold Intolerance ❑ Weight Change ❑ Diabetes❑ Hair Change ❑ Excessive Sweating ❑ Urinary Frequency ❑ Voice Change ❑ Excessive Thirst
NEUROLOGIC	❑ **NONE** ❑ Headache ❑ Fainting ❑ Seizures ❑ Dizziness ❑ Blindness ❑ Double Vision ❑ Paralysis ❑ Tremor ❑ Pain ❑ Numbness ❑ Tic ❑ Tingling Sensation ❑ Burning Sensation ❑ Lack of Coordination
PSYCHIATRIC & EMOTIONAL	❑ **NONE** ❑ Anxiety ❑ Sleep Disturbances ❑ Depression ❑ Nervousness ❑ Tension ❑ Thoughts of Suicide ❑ Emotional Instability ❑ Delusions ❑ Memory Loss ❑ Hallucinations

THE INFORMATION ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ **Parent/ Guardian/ Patient Signature and Date**

_____ **Initials / Date** _____ **Initials / Date** _____ **Initials / Date**

_____ **Provider Signature and Date**

_____ **Initials / Date** _____ **Initials / Date** _____ **Initials / Date**

_____ **Initials / Date** _____ **Initials / Date** _____ **Initials / Date**