Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA, 23507-1910

CHILDREN'S SURGICAL SPECIALTY GROUP

PATIENT QUESTIONNAIRE

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

PATIENT NAME ____________________
First Name Middle Name Last Name

DATE OF BIRTH ____________________ **AGE** ________ years, ________months

HOME PHONE ____________________ **CELL PHONE** ____________________

E-MAIL ADDRESS ____________________

PRIMARY CARE PHYSICIAN (PCP) ____________________

PCP'S ADDRESS ____________________
Street Address City State Zip

PCP'S PHONE NUMBER (__________) ____________________

Did a physician *other than your PCP* refer you? ❑ No ❑ Yes (PLEASE LIST BELOW):

____
First Name Last Name Street Address City State Zip Phone

Are there other physicians involved in your child's care? ❑ No ❑ Yes (Please list their name(s) below):

____

WHAT PROBLEM WOULD YOU LIKE US TO EVALUATE TODAY? ____________________

____

____

CURRENT MEDICAL PROBLEMS: ____________________

____

____

PRIOR MEDICAL PROBLEMS/ ILLNESSES/ HOSPITALIZATIONS? ❑ No ❑ Yes

(Please state illness, dates, treatment and duration): ____________________

____

____

____

PRIOR INJURIES? ❑ No ❑ Yes (Please state type of injury, date and treatment): ____________________

____

PRIOR SURGERY? ❑ No ❑ Yes (Please state type of surgery and date): ____________________

____

____

____

PRIOR X-RAYS? ❑ No ❑ Yes (Please state type of x-ray and date – USE BACK OF SHEET IF NECESSARY):

____

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

____

OBSTETRICAL (BIRTH) HISTORY:

WAS THE CHILD FULL TERM? ❑ Yes ❑ No (If no, gestational age):__________weeks gestation

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

WEIGHT AT BIRTH: _______pounds, _______ounces **LENGTH AT BIRTH:** _______inches

PRENATAL ISSUES? ____________________

____

____

Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA, 23507-1910

CHILDREN'S SURGICAL SPECIALTY GROUP

PATIENT QUESTIONNAIRE

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

CURRENT MEDICATIONS:

Drug ______________________ Dose ____________ Frequency ____________
Drug ______________________ Dose ____________ Frequency ____________
Drug ______________________ Dose ____________ Frequency ____________
Drug ______________________ Dose ____________ Frequency ____________
Drug ______________________ Dose ____________ Frequency ____________

ALLERGIES TO MEDICATIONS? ❑ No ❑ Yes (Please list medication and reaction to that medication!!!):

____
____
____
____

ALLERGIES TO FOOD AND ENVIRONMENTAL? ❑ No ❑ Yes (Please list with reaction): ____________
____

ALLERGIES TO LATEX? ❑ No ❑ Precautions Only ❑ Yes (explain reaction): ____________

ALLERGIES TO METAL OBJECTS? ❑ No ❑ Yes (Please list with reaction): ____________

ARE IMMUNIZATIONS UP TO DATE? ❑ Yes ❑ No (explain): ____________

ADDITIONAL 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 FAMILY MEDICAL HISTORY RELEVANT TO THIS VISIT? ❑ No ❑ Yes (Please provide details): ____________
____

IS THERE A FAMILY HISTORY OF SICKLE CELL DISEASE OR SICKLE CELL TRAIT? ❑ No ❑ Yes ____________

IS THERE A FAMILY HISTORY OF ADVERSE REACTIONS TO ANESTHESIA? (HIGH FEVER, WEAKNESS) ❑ No ❑ Yes

Explain any family anesthesia reactions: ____________

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

Explain any Genetic/Bleeding Disorders: ____________

SOCIAL HISTORY:

WITH WHOM DOES THE PATIENT CURRENTLY RESIDE? ____________

SCHOOL: ______________________ **GRADE:** __________

IS THE PATIENT ACTIVE IN SPORTS OR OTHER ORGANIZED ACTIVITIES? ❑ No ❑ Yes (state the sport/type of activity):
____

HAS THE PATIENT HAD A HISTORY OF DRUG, ALCOHOL AND/OR TOBACCO USE? ❑ No ❑ Yes

If yes, please state the type and duration ____________

IS THE PATIENT SEXUALLY ACTIVE? ❑ No ❑ Yes (If yes, please state for how long): ____________

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

DEVELOPMENTAL MILESTONES: ❑ Normal ❑ Delayed

ROLLING OVER: ❑ Yes, age:______ ❑ NO CRAWLING: ❑ Yes, age:______ ❑ NO
SITTING UP: ❑ Yes, list age:______ ❑ NO WALKING: ❑ Yes, list age:______ ❑ NO

Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA, 23507-1910

CHILDREN'S SURGICAL SPECIALTY GROUP
PATIENT QUESTIONNAIRE

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

PATIENT 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** ❑ CIRCUMCISED ❑ Pain ❑ Skin Lesions ❑ 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.

________________ ____

Date Parent/ Guardian/ Patient Signature

THIS SECTION FOR OFFICE USE ONLY:

________________ ________________________________ ____________ ____________ ____________

Date Provider Signature Initials / Date Initials / Date Initials / Date

____________ ____________ ____________

Initials / Date Initials / Date Initials / Date