Carolina Pediatric Surgery

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New Patient Medical Questionnaire

Patient Name_____DOB_____
Person Filling Out This Form? (circle): Patient Mother Father Other:_____

Please circle one. If YES, please explain in the lines provided to the right.

A. PREGNANCY AND BIRTH: (skip for adults)

1. Did mother have any illness during pregnancy? No Yes _____ Vaginal or cesarean? _____
2. What was the birth weight? _____
3. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes _____

B. PAST MEDICAL AND SURGICAL HISTORY:

1. Any serious past medical problems? No Yes _____
2. Any past surgery? No Yes _____Date(s): _____
3. Any problems with anesthesia? No Yes _____
4. Any problems with bleeding after surgery? No Yes _____
5. Date of last checkup: _____
6. Any **allergic reactions** to any medications, foods? No Yes _____ Type of reaction:_____
7. Any hospitalizations? No Yes _____
8. **Regular medications?** No Yes (please list) _____
   _____
   _____
9. Has the patient had any of the following?
   Ear problems? No Yes _____ High blood pressure? No Yes _____
   Eye problems? No Yes _____Problems with teeth? No Yes _____
   Asthma, pneumonia? No Yes _____ Heart problems? No Yes _____
   Problems with urination? No Yes _____ Gastrointestinal problems? No Yes _____
   Convulsions/central nervous system problems? No Yes _____Skin conditions? No Yes _____
   Kidney problems? No Yes _____ Depression, anxiety, ADHD? No Yes_____

C. FAMILY HISTORY:

Please check if mother (M), father (F), siblings (S), maternal or paternal grandparent (MGF, MGM, PGF, PGM.) had any: Birth defect _____High Blood Pressure_____ Cystic fibrosis _____Sickle cell _____
Diabetes _____Bleeding disorder _____ Kidney disease _____Obesity _____
Cancer _____ Thyroid disease _____ High Cholesterol _____

D. SOCIAL HISTORY:

1. Does the patient live with: Mother_____ Father_____ Both_____ Other _____
2. How many siblings at home? _____ Any one sick at home? No Yes_____
3. What grade if in school: _____ Name of school: _____Sports: No Yes _____
4. Occupation (if any): _____ Any secondhand smoke exposure or smoking? No Yes_____
5. Any recreational drugs? No Yes _____ Regular Alcohol intake? No Yes _____

Patient/Parent signature _____ **Date:** _____