Beaumont Children's Hospital
Pediatric Surgical Group Questionnaire

Patient's name: _____ Today's date:_____

Date of birth: _____ Age:_____ Pt. Weight/Height: _____/_____

Pediatrician/Referring Physician:_____ Phone: _____

Reason for today's visit:_____

_____

Allergies	List Reaction	Allergies	List Reaction
1.		3.	
2.		4.	

Current Medications:
Please list all prescription and over-the-counter medications your child is currently taking:

Medication Name/Dose/Frequency	Medication Name/Dose/Frequency
1.	**3.**
2.	**4.**

Birth History (For children under 5 years of age):

Term of pregnancy ☐ Full Term ☐ Preterm # of weeks gestation: _____

Birth weight:_____ ☐ NICU length of stay:_____

Complications/problems first month of life: _____

_____

_____

Child's Past Medical History: Please list any chronic health conditions (Heart/Lung/Kidney), hospitalizations, serious illnesses, or recent trauma/injury (Include dates):

_____

_____

Child's Past Surgical History: Please list any previous or recent surgeries your child has had in the past**.**

_____

_____

Immunizations up to date: ☐ Yes ☐ No

Date of last menstrual period (if applicable): _____

Family medical history: (Cancer, Diabetes, Heart disease, High Blood Pressure, Stroke, etc.)

Father:		
Mother:		
Siblings: 1. 2. 3.		
Grandparents:	Maternal	Paternal
	Grandmother _____ Grandfather _____	Grandmother _____ Grandfather _____

PLEASE COMPLETE OTHER SIDE

Is there any family history of anesthesia problems, bleeding/blood clotting disorders? ☐ Yes ☐ No
If yes, please explain: _____

Social History:

School: Grade Level_____ Daycare (How many days/week):_____ Foster care: ☐ Yes

Second hand smoke exposure: ☐Yes ☐ No Pets: _____

Favorite Activities/Sports/Hobbies: _____

Lives with: _____ # of siblings & ages: _____

Review of Symptoms:

Please check symptoms your child is **currently having**: (Check all that apply)

	YES	NO		Yes	NO		Yes	NO
CONSTITUTIONAL			**CARDIOVASCULAR**			**NEUROLOGICAL**		
Abnormal weight loss			Chest pain			Seizures		
Fever/chills/night sweats			Chest palpitations/Rapid heartbeat			Headache		
Decreased Appetite/anorexia			Fainting			Dizziness		
Weakness/fatigue			Heart murmur			Head trauma		
Frequent illnesses			Pale or blue lips/skin			Sleeping issues		
EARS, EYES, NOSE, MOUTH, THROAT			**RESPIRATORY**			**URINARY**		
Ear pain/problems			Wheezing/ Shortness of breath			Urinary reflux		
Hearing loss			Persistent cough			Difficulty urinating		
Nose bleeds/discharge			Exercise intolerance			Frequent urination		
Sore throat			**GASTROINTESTINAL**			Bedwetting		
Sinus disease			Abdominal pain			**PSYCHIATRIC**		
Trouble swallowing			Heartburn			Depression		
Blurred/worsening vision			Nausea/vomiting			Anxiety/Nervousness		
Snoring			Bloating/cramping			Difficulty concentrating		
HEMI-LYMPHATIC			Diarrhea			Emotional instability		
Swollen lymph nodes			Constipation			**IMMUNOLOGICAL**		
Easy bruising			Bloody stools			Recurrent infection		
Neck swelling/pain			Difficulties with bowel control			Allergic reaction		

History reviewed by: _____ _____

Physician/NP Signature Date