NEW / RETURN - PATIENT QUESTIONNAIRE

Patient Name: _____

Reason for Today's Visit: _____

Pediatrician: _____ location: _____

Referring Physician: _____ location: _____

Pharmacy: _____ location: _____

PAST MEDICAL HISTORY:

Does your child *have* or *have they been treated* for any of the following (check all that apply)?

_____AIDS/HIV
_____allergies
_____asthma
_____reflux
_____noisy breathing
_____sleep apnea
_____hearing loss
_____ear disease
_____bleeding disorder
_____other:_____
_____sickle cell anemia
_____tuberculosis (TB)
_____seizures
_____heart disease
_____lung disease
_____kidney disease
_____meningitis
_____cancer (type:_____)
_____transplant (type:_____)

HOSPITALIZATIONS (please list):

Date Reason Hospital

SURGERIES (please list):

Date Surgery Hospital

CURRENT MEDICATIONS (please include name, dose and frequency taken):

Do you have any ALLERGIES TO MEDICATIONS? _____ YES _____ NO

If yes, please list the medicine and describe the reaction:

BIRTH HISTORY:

Was your child born prematurely? _____ YES _____ NO

If Yes, by how many weeks? _____

What was your child's birth weight? _____

Has your child ever needed a breathing tube or ventilator? _____ YES _____ NO

Did you child pass their newborn hearing screening test? _____ YES _____ NO

Did your child have any problems at the time of delivery? (please list)

_____

_____

SOCIAL HISTORY:

Are your childs immunizations up to date? _____ YES _____ NO

Is your child currently in day care? _____ YES _____ NO

Is your child exposed to tobacco smoke? _____ YES _____ NO

Is there concern for suspected abuse, physical assault, molestation/rape, domestic violence, unsafe living situation, or substance abuse in the home? ____ YES ____ NO

BEACON PROGRAM: 919-966-9314

FAMILY HISTORY (please check all that apply to your family members):

_____allergy
_____asthma
_____cystic fibrosis
_____ear infections
_____hearing loss or deafness
_____bleeding disorder
_____problems with anesthesia
_____thyroid disease
_____cancer (type:_____)

BELOW THIS LINE FOR STAFF ONLY

NURSING ASSISTANT:

BP: _____/_____ Weight (kg): _____ Height (in): _____ Temp: _____ Pulse: _____ Resp: _____

Pain: 0 1 2 3 4 5 6 7 8 9 10

Plan:

Audio _____ Speech Path _____ CT _____ MRI _____ MBSS _____ Sleep Study _____

Referral:_____

RTC Dr. Rose: _____(or p.r.n.)

Preop for OR:_____