34474-08

Children's Healthcare of Atlanta
Pediatric Surgery Practice

NEW PATIENT QUESTIONNAIRE

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Sex F M	Home Number/Cell Number /	Primary Doctor
Why are you here to see the doctor		

History: Please explain any YES answers in detail in the box provided

Does your child have any allergies (including environmental, medication, food or reaction to previous blood transfusion?	☐ Yes ☐ No	If yes, please describe the reaction.
Are your child's immunizations up to date?	☐ Yes ☐ No	
Has your child been exposed to measles, mumps, or chicken pox in the last 7-21 days?	☐ Yes ☐ No	
Has your child or has anyone in frequent contact with your child traveled out of the country in the last 21 days?	☐ Yes ☐ No	
Does your child have any special needs? (physical or emotional)	☐ Yes ☐ No	
Has your child ever had any surgeries or been hospitalized?	☐ Yes ☐ No	
Has your child ever had either general anesthesia or sedation?	☐ Yes ☐ No	
Is there a family history of problems with anesthesia?	☐ Yes ☐ No	

Please check the box by the method of learning that works best for you. ☐ **Reading** ☐ **Listening** ☐ **Pictures/Videos** ☐ **Demonstration** ☐ **Hands On** ☐ **Interpreter preferred language**_____ ☐ **Special Instructions:**

How often do you need someone to help you when you read instructions, pamphlets or other written materials from your doctor, nurse, therapist or pharmacist? ☐ **Never** ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always**

Family History: Please indicate if the patient's parents, grandparents, brothers or sisters have had any of the following conditions.

Condition	Relation to Patient	Condition	Relation to Patient
Birth Defects		Urinary/Kidney Problems	
Stomach /Intestinal Problems		Bleeding Problems (Sickle Cell)	
Breathing Problems		Heart Disease	

Children's Healthcare of Atlanta
Pediatric Surgery Practice

NEW PATIENT QUESTIONNAIRE

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Medical History: Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided.

History	Explanation/Details
Birth History ☐ Normal - full term ☐ Caesarean ☐ Premature	
Prematurity ☐ Apnea ☐ Mechanical Ventilation ☐ BPD(Bronchopulmonary Dysplasia) ☐ Bradycardia ☐ Intubation ☐ ROP (Retinopathy)	
Gastrointestinal ☐ Diarrhea ☐ Vomiting ☐ Constipation ☐ GE Reflux	
Ear ,Nose, Throat ☐ Upper Respiratory Infection/Cold ☐ Loose Teeth ☐ Braces ☐ Deafness ☐ Blindness ☐ Snoring ☐ Ear Infection ☐ Nose Bleeds ☐ Difficulty Swallowing ☐	
Cardiac ☐ Blood Pressure Problems ☐ Arrythmias (Irregular Heartbeat) ☐ Cardiotoxic Drugs ☐ Palpitations ☐ Congenital Abnormalities ☐ Murmurs	
Respiratory ☐ Asthma ☐ TB ☐ Croup ☐ Pneumonia ☐ Bronchitis ☐ Aspiration ☐ Chronic Cough ☐ Tracheotomy ☐ RSV(Respiratory Syncytial Virus)	
Musculoskeletal ☐ Muscle Disease ☐ Scoliosis ☐ Arthritis ☐ Fractures ☐ Muscular Dystrophy ☐ Neck Pain ☐ Back Pain ☐ Hypotonic	
Blood Disorders ☐ Bleeding Disorder ☐ Sickle Cell Disease ☐ G6PD Deficiency ☐ Prior Transfusion ☐ Anemia ☐ Lymphoma ☐ Leukemia ☐ Thalassemia ☐ Easy Bleeding/Bruising	
Genitourinary ☐ Kidney Disease ☐ Urinary Tract Infection	

Children's Healthcare of Atlanta
Pediatric Surgery Practice

NEW PATIENT QUESTIONNAIRE

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Hepatic ☐ Liver Disease ☐ Jaundice (yellow skin) ☐ Hepatitis	
Skin ☐ Rash ☐ Birthmarks ☐ Bruises ☐ Eczema ☐ Scars ☐ Hemangioma	
Endocrine/Metabolic ☐ Diabetes ☐ Inborn Errors of Metabolism ☐ Thyroid Disorders ☐ Adrenal Disorders	
Neurologic ☐ Seizures ☐ Weakness ☐ Migraines ☐ Epilepsy ☐ IVH ☐ Sympathy ☐ Hydrocephalus	
Psychosocial ☐ Developmental Delay ☐ Substance Abuse ☐ Learning Disability ☐ ADD ☐ Autism	

Please list the current medication your child is taking. This will allow us to have a complete list for consideration when choosing medications for your child today.

☐ **My child is not on any medicines right now.**

Please list all of your child's medicines.

	Medicine - Please list the name of each medicine your child takes	**How much does your child take?** Such as 2ml, 5mg, or 1 tsp	**How often does your child take it?** Such as once a day, twice a day
☐	**Pain Medication**		
☐	**Antibiotic**		
☐	**Allergy/Cold/Cough Medicine**		
☐	**Asthma/Wheezing Medicine**		
☐	**Behavior Medicine**		
☐	**Eye/Ear Drops**		
☐	**Herbal Medicines**		
☐	**Vitamins/Nutritional Supplements**		
☐	**Other Medicines**		

Parent Signature_____ Date_____ Time_____

Reviewed By:_____ Date_____ Time_____