



Carolina Pediatric Surgery

Patient's Name: _____ Date: _____ Date of Birth: _____
Reason for Visit: _____ Referring Physician: _____

SOCIAL HISTORY

If we need to teach you something relating to your child's health, would you prefer us to:

(Check all that apply) Give you written information tell you the information show you how to do something new

Do you the parent/guardian have any problems that would affect your understanding:

(Check all that apply) None Illness Speech Vision Able to read Difficulty reading Unable to read
 Emotional Physical

Patient's Primary Language: English Spanish Other: _____

Parent/ Guardian's Primary Language: English Spanish Other: _____

Do you have reliable means of transportation to and from doctor? Yes No

Do you have a car seat (for child less than 8 years old or less than 80 pounds)? Yes No N/A

Does the home of the child have? **Electricity** Yes No **Telephone** Yes No **Running Water** Yes No Well City
(if well water, is child on fluoride) Yes No

Does your home have smoke detectors? Yes No

Are there any firearms in your home? Yes No

Does anyone living with child smoke? Yes No If yes who: _____

Who lives with patient? Mother Father

Single Divorced Separated Married

Name of Siblings: _____

Others living in the household: _____

PATIENT HISTORY

Describe your child's health: _____

Birth Weight: _____ Complications at Birth: _____

Preterm: Yes No How early: _____ City Born In: _____

What hospital was your child born at? _____

Has your child ever been hospitalized? Yes No Reason: _____

If yes, when and at what hospital: _____

Has your child ever had surgery? Yes No

What kind of surgery, please include dates: _____

Where was the surgery performed: _____

Does your child have any problems with the following: (Please check yes or no)

Yes	No		Yes	No		Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Behavior/Discipline	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Trouble in School
<input type="checkbox"/>	<input type="checkbox"/>	Temper Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Learning Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Breath holding
<input type="checkbox"/>	<input type="checkbox"/>	Toilet Training	<input type="checkbox"/>	<input type="checkbox"/>	Speech	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity									

Physician Signature: _____ Date: _____

Patient's Name: _____ Date: _____ Date of Birth: _____
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MEDICATION HISTORY

Is your child on any current medications (prescribed / non-prescribed/ herbs and vitamins)? Yes No

If yes, please list medications below:

Name of Medication (strength if applicable)	How Much?	How Often?	Last Dose Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How does your child take medication best? Liquid/ Syrup Tablets/Capsules (swallows) Chewable/Crushed Pills

Has never taken medication before Other, please describe: _____

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IMMUNIZATIONS

Are your child's immunizations up to date? Yes No

If no, last shot(s) received and date: _____ Where does your child receive their immunizations: _____

Do you have a copy of your child's immunization record with you? Yes No Has your child had a TB skin test? Yes No

If yes, date of last TB skin test: _____ Results: _____

Has your child had any of the following childhood illnesses:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES

Does patient have any allergies? Yes No - If yes please list below:

Medication, Food, Environmental, Latex Allergy:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Physician Signature: _____ Date: _____

Patient's Name: _____ Date: _____ Date of Birth: _____
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REVIEW OF SYSTEMS: PATIENT

Please check yes or no to the following problems:

CONSTITUTIONAL

- | | | | | | | | | |
|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic pain | <input type="checkbox"/> | <input type="checkbox"/> | ill feelings | <input type="checkbox"/> | <input type="checkbox"/> | weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> | fever | <input type="checkbox"/> | <input type="checkbox"/> | chills | | | |

HEMATOLOGY/IMMUNOLOGY

- | | | | | | | | | |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|---------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic allergies | <input type="checkbox"/> | <input type="checkbox"/> | difficulty fighting off illness | <input type="checkbox"/> | <input type="checkbox"/> | easy bruising |

EYES/NOSE/TROAT

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|------------|--------------------------|--------------------------|---------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | cataracts | <input type="checkbox"/> | <input type="checkbox"/> | cross eyed | <input type="checkbox"/> | <input type="checkbox"/> | blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | runny nose | <input type="checkbox"/> | <input type="checkbox"/> | sinus pain | <input type="checkbox"/> | <input type="checkbox"/> | swallowing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | painful swallowing | | | | | | |

HEART

- | | | | | | | | | |
|--------------------------|--------------------------|--------------|--------------------------|--------------------------|------------|--------------------------|--------------------------|---------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | palpations | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain | | | | | | |

LUNGS

- | | | | | | | | | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> | persistent cough | <input type="checkbox"/> | <input type="checkbox"/> | productive cough |
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain | | | | | | |

GI SYSTEM

- | | | | | | | | | |
|--------------------------|--------------------------|----------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|----------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | constipation | <input type="checkbox"/> | <input type="checkbox"/> | abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | vomiting | <input type="checkbox"/> | <input type="checkbox"/> | blood in stool | | | |

GU SYSTEM

- | | | | | | | | | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | frequent urination | <input type="checkbox"/> | <input type="checkbox"/> | burning when urinating |
| <input type="checkbox"/> | <input type="checkbox"/> | difficulty urinating | | | | | | |

NEUROLOGICAL

- | | | | | | | | | |
|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | headaches | <input type="checkbox"/> | <input type="checkbox"/> | unsteadiness | <input type="checkbox"/> | <input type="checkbox"/> | problems concentrating |

MUSCULOSKELETAL

- | | | | | | | | | |
|--------------------------|--------------------------|------------|--------------------------|--------------------------|-----------------|------------|-----------|--|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | joint pain | <input type="checkbox"/> | <input type="checkbox"/> | muscle weakness | | | |

SKIN

- | | | | | | | | | |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------|--------------------------|--------------------------|-------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | change in mole | <input type="checkbox"/> | <input type="checkbox"/> | rashes | <input type="checkbox"/> | <input type="checkbox"/> | sore that does not heal |

PSYCHIATRIC

- | | | | | | | | | |
|--------------------------|--------------------------|------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|---------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | depression | <input type="checkbox"/> | <input type="checkbox"/> | mood swings | <input type="checkbox"/> | <input type="checkbox"/> | anxiety |

Physician Signature: _____ Date: _____

Patient's Name: _____ Date: _____ Date of Birth: _____

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FAMILY HISTORY

Please describe any health conditions in your family. Please include the child's parents, brothers, sisters, grandparents (maternal and paternal), aunts and uncles. (check the condition and identify who has the condition in the blank space).

PROBLEMS	NO PROBLEMS	WHO	WHAT
<input type="checkbox"/>	<input type="checkbox"/>		Breathing or Lung Disease (Asthma, Bronchitis, CF, other Lung Disease)
<input type="checkbox"/>	<input type="checkbox"/>		Joints, Muscles, Extremities
<input type="checkbox"/>	<input type="checkbox"/>		Endocrine (Glandular Problems, Diabetes, Thyroid Disease)
<input type="checkbox"/>	<input type="checkbox"/>		Heart or Blood Vessels (Hole in Heart, Murmur, High Blood Pressure, Heart Attack)
<input type="checkbox"/>	<input type="checkbox"/>		Neurological System (ADHD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)
<input type="checkbox"/>	<input type="checkbox"/>		Psychological or Mental Health (Depression or Anxiety)
<input type="checkbox"/>	<input type="checkbox"/>		Blood Disease (SCA, Sickle Trait)
<input type="checkbox"/>	<input type="checkbox"/>		Constitutional (Chronic Pain, Unexplained Ill Feelings, Cancer, Leukemia, High Cholesterol)
<input type="checkbox"/>	<input type="checkbox"/>		Chemotherapy/Radiation
<input type="checkbox"/>	<input type="checkbox"/>		Immunology (Chronic Allergies, Weak Immune System)
<input type="checkbox"/>	<input type="checkbox"/>		Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)
<input type="checkbox"/>	<input type="checkbox"/>		Eyes (Cataracts, Cross Eyed)
<input type="checkbox"/>	<input type="checkbox"/>		Ears, Nose, Mouth, and Throat
<input type="checkbox"/>	<input type="checkbox"/>		Bladder and Kidney (Chronic Bladder Infection, Kidney Failure)
<input type="checkbox"/>	<input type="checkbox"/>		Skin

Would you like this form to be used for other siblings: Yes No

Names of children you would like form used for: _____

Signature of Person Filling Out Form: _____

Physician Signature: _____ Date: _____

H&P Reviewed and Updated By: _____ Date: _____