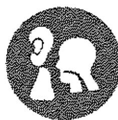

Douglas C. McCorkle, M.D., F.A.C.S.

PEDIATRIC QUESTIONNAIRE

LAST NAME ______________________ FIRST NAME ______________________ M.I. ________

PARENT/GUARDIAN/EMERGENCY CONTACT: ______________________ (PHONE) ______________

AGE ___ DATE OF BIRTH ____________ MALE/FEMALE HEIGHT __________ WEIGHT __________

PEDIATRICIAN ____

PHARMACY NAME: ______________________ PHONE NUMBER: ______________________

REASON FOR TODAY'S VISIT: ____

MEDICATION ALLERGIES AND REACTION: ______________________ LATEX ALLERGY? YES/NO

***PAST MEDICAL HISTORY*:**

Was patient born full term? Yes/No ______weeks Vaginal C-section (circle one)

Complications with pregnancy or delivery? Yes/No ______________________________

Pass Newborn Hearing Test? Yes/No Are Immunizations up to date? Yes/No

Developmental delays? Yes/ No Describe: ______________________________

SOCIAL HISTORY:

Is the patient in daycare? Yes/No Current grade in school __________ Pets in household? ______________

Are there any siblings? Ages ______________________ Is patient exposed to second hand smoke? Yes/No

Please circle any of the following conditions the patient has or has had in the past:

Autism	Asthma	Seizure Disorder
Chronic Ear Disease	Acid Reflux	Hearing Loss
Chronic Sinusitis	Psoriasis/Eczema	Seasonal Allergies
Failure to Thrive	ADHD/ADD	Sleep Apnea
Mouth Breathing	Snoring	Blood Clotting Disorder
Heart Problems (Cardiac)	Ear Aches	Anesthesia complications

Is there a Family History of Hearing Loss? Yes____No______

Other Medical Problems: ____

Please list any medications and dosages:

MEDICATION ______________________ DOSE ______________________

MEDICATION ______________________ DOSE ______________________

MEDICATION ______________________ DOSE ______________________

***PLEASE LIST ALL SURGERIES AND DATES*:**

SURGERY ________________________________ DATE ________________________

SURGERY ________________________________ DATE ________________________

SURGERY ________________________________ DATE ________________________

***FAMILY HISTORY*: CIRCLE conditions that run in the family:**

Asthma/ Seasonal Allergies   Bleeding/Clotting Disorder   Anesthesia Complications

***REVIEW OF SYSTEMS*: CIRCLE ALL that patient has experienced in last 3 months:**

CONSTITUTIONAL:	unexplained weight loss weight gain fever chills fatigue
EYES:	corrective lens blurry vision double vision eye pain redness watering
ENT:	headaches difficulty swallowing nose bleeds ringing in ears ear aches hearing loss
CARDIOVASCULAR:	chest pain palpitations fainting murmurs
RESPIRATORY:	shortness of breath wheezing cough chest tightness pain with breathing snoring
GASTROINTESTINAL:	heartburn nausea vomiting constipation diarrhea bloody/tarry stools
GENITOURINARY:	bedwetting urinary frequency urgency difficult or painful urination flank pain bleeding with urination
MUSCULOSKELETAL:	joint pain swelling stiffness
SKIN:	skin changes sore that won't heal rash itching redness hives
HEMATOLOGIC:	easy bleeding bruising
NEUROLOGICAL:	numbness tingling dizziness unsteady gait
PSYCHIATRIC:	hyperactivity anxiety depression
ENDOCRINE:	excessive thirst heat tolerance cold tolerance
ALLERGIC:	reaction to foods or environment

PARENT/GUARDIAN SIGNATURE ________________________________ DATE: ____________