Pediatric Health History Questionnaire:

Child's name_____ Date of birth_____

Mother's name: _____ Father's name:_____

Address_____

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
Fever or rash	Tobacco use (how much)
Group B strep	Alcohol use (how much)
Sugar in urine / diabetes	Street drug use (what type)
High blood pressure	Medication use (prescription or over-the-counter - list below)
Anemia	
Infections (if yes what type and how were they treated)	

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? Early	Late	How much:
Type of delivery Vaginal	C-section (why):	
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following		
Feeding trouble	Seizures	Fever
Excess vomiting	Breathing trouble	Receive antibiotics
Jaundice (yellow skin)	Need of oxygen	Diarrhea
Cyanosis (blueness)	Blood transfusion	In intensive care unit

Family History				
Relationship	Name	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father				
Mother				
Siblings				
If more than 3 siblings continue on back				

Specifically have any of the child's relatives had the following conditions

Condition	Relative	Condition	Relative
Diabetes		Kidney problems	
Cancer		Heart disease	
Seizures		Stroke	
Allergies/asthma		Anemia	
Bleeding problems		HIV	
High blood pressure		Skin problems	
Lung disease		Chemical dependency	
Mental illness		Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

Past Medical History
Where has child gone for check-ups previously:

Date of last medical checkup:
Date of last dental check-up:
Is your child up-to-date on immunizations? Please supply immunization records.

Has your child had any of the following		
Chicken pox	Wears glasses	Asthma
Measles	Heart murmur	Allergies
Mumps	Kidney or bladder infection	Broken bones
Frequent ear infections (>4 year)	Bed wetting (>5 years old)	Head injury
Frequent throat infections (>4 year)	Diabetes	Seizures

Has your child ever been hospitalized or had surgery? If yes, list age and reason:
Has your child ever been on medication regularly that is not on their current medication list? If yes, list medication(s) and reason:
Do you have any concerns about your child's development? If yes, please describe:

Childs Social Characteristics	
School Grade/Preschool:	City Water: Yes / No
Hours of TV/Electronics Each Day:	Exposure to Second Hand Smoke: Yes / No
Special Diet:	Guns in Home: Yes / No
Weekly Hours of Outdoor Activity:	Wears Sunscreen: Yes / No
Pets:	Wears Seatbelt/Car Seat/Booster: Yes / No
Sports:	
Hobbies:	

Allergies	
Please list any allergies to medications or foods and environmental allergies	

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency (if more room is needed continue on back)	

Specialty Providers
In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them (if more room is needed continue on back)

Parent Signature:_____ Date:_____