

Pediatric Health History Questionnaire:



Child's name _____ Date of birth _____
 Mother's name: _____ Father's name: _____
 Siblings names and ages: _____
 Address _____

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

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Specifically have any of the child's relatives had the following conditions			
Condition	Relative	Condition	Relative
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney problems	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Seizures		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Allergies/asthma		<input type="checkbox"/> Anemia	
<input type="checkbox"/> Bleeding problems		<input type="checkbox"/> HIV	
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Skin problems	
<input type="checkbox"/> Lung disease		<input type="checkbox"/> Chemical dependency	
<input type="checkbox"/> Mental illness		<input type="checkbox"/> Other:	

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

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? <input type="checkbox"/> Early <input type="checkbox"/> Late	How much:	
Type of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> 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		
<input type="checkbox"/> Feeding trouble	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fever
<input type="checkbox"/> Excess vomiting	<input type="checkbox"/> Breathing trouble	<input type="checkbox"/> Receive antibiotics
<input type="checkbox"/> Jaundice (yellow skin)	<input type="checkbox"/> Need of oxygen	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Cyanosis (blueness)	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> In intensive care unit

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?

If yes, list medication(s) and reason:

Do you have any concerns about your child's development?

If yes, please describe:

Allergies

Please list any allergies to medications or foods

Medications

Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency

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

Parent Signature: _____ Date: _____