Pediatric Health History Questionnaire:

Child's name _____ Date of birth _____

Mother's name: _____ Father's name _____

Address _____

FAMILY - PAST MEDICAL HISTORY

	NO	YES	IF YES, Please check which biological relative							
			Mom	Dad	Brother	Sister	Maternal Gr Mthr	Maternal Gr Fthr	Paternal Gr Mthr	Paternal Gr Fthr
Nasal allergies or other allergies										
Asthma / Lung Disease										
Heart Disease or Heart Condition										
High Blood Pressure										
High Cholesterol										
Diabetes or other Endocrine Problem										
Cancer										
Anemia										
Bleed Disorders										
Epilepsy or Convulsions										
Intellectual Disability or Developmental Disorder										
Neurological Disorder including ADHD / ADD										
Liver Disease										
Other GI Disease / Disorder										
Kidney Disease										
Bed-wetting (after age 10)										
Hearing Impairment										
Vision Impairment or Eye Disorder										
Immune Problems, Recurrent Infections or HIV-AIDS										
Alcohol Abuse										
Drug Abuse										
Mental Illness										
Tuberculosis										
Other Issues:										

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 DOES 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

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 Veginal	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 Vomitting	Breating Trouble	Receive Antibiotics
Jaundice (yellow skin)	Need of Oxygen	Diarrhea
Cyanosis (blueness)	Blood Transfusion	In Intensive Care Unit

PAST MEDICAL HISTORY		
Where has child gone for check-ups previously?:		
Date of last medical check-up:		
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 years old)	Bed Wetting (> 5 years old)	Head Injury
Frequent throat infections (>4 years old)	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:	

SPECIAL COMMUNICATION NEEDS:			
Language Preference			
If 'yes' to any of the questions below, how can we assist?			
Visual Impairment	Yes / No	Cognitive Impairment	Yes / No
Hearing Impairment	Yes / No	Sensory Impairment	Yes / No
Speech Impairment	Yes / No	Other:	

Parent Signature: _____ Date: _____