PEDIATRIC-PATIENT QUESTIONNAIRE

Completed by: _____ Relation: _____

Name: _____ Date of Birth: _____ Nickname: _____

Reason for today's visit: _____

Previous medical care - Dr.: _____ City: _____ Dental Care: ☐ Y ☐ N Eye Exam: ☐ Y ☐ N

PREGNANCY & BIRTH

Is your child adopted? _____ From where? _____

Any illness during pregnancy? ☐ Y ☐ N

Medications during pregnancy? ☐ Y ☐ N

☐ Smoking - ☐ alcohol - ☐ street drugs - during pregnancy? _____

Was baby: ☐ early (how early? _____ ☐ late (how late? _____ ☐ on time?

Type of delivery? _____ Birth weight: _____ Length: _____

Complications? ☐ Y ☐ N Apgar: _____

Problems with baby at birth? ☐ Y ☐ N Jaundice ☐ Y ☐ N

Other: _____

PAST MEDICAL HISTORY

Allergies to medicine? ☐ Y ☐ N If so, what? _____

Does your child have any other allergies (food, dust, pollen, insect stings)?

Medications taken on a regular basis: _____

Has your children been hospitalized or had surgery? _____

Date	City/State	Hospital	Reason

Does your child have any of the following?

- ☐ anemia/sickle cell disease
- ☐ asthma/wheezing
- ☐ bleeding tendency
- ☐ blood transfusions
- ☐ bronchitis/pneumonia
- ☐ chicken pox/when _____
- ☐ constipation/diarrhea
- ☐ diabetes
- ☐ eating problems
- ☐ eye problems
- ☐ frequent colds
- ☐ frequent ear infections
- ☐ frequent fevers
- ☐ frequent sore throats
- ☐ frequent stomach aches
- ☐ hayfever/allergies
- ☐ hearing/speech problem
- ☐ heart problems
- ☐ hernia
- ☐ hip/leg/foot problems
- ☐ kidney/bladder problems
- ☐ loss of consciousness
- ☐ migraines/headaches
- ☐ skin problems/hives/eczema
- ☐ seizures/convulsions
- ☐ serious injury _____
- ☐ tuberculosis
- ☐ other _____

FEEDING & NUTRITION

Food Allergies? _____

Appetite usually good? ☐ Y ☐ N

Colic or feeding problems during the first 3 months? ☐ Y ☐ N

Breast fed? ☐ Y ☐ N Number of months? _____

Formula? ☐ Y ☐ N Current Brand? _____

Vitamins? ☐ Y ☐ N Brand _____ Fluoride? ☐ Y ☐ N

Special Diet? ☐ Y ☐ N Does your child drink fluoridated water? ☐ Y ☐ N

FAMILY PROFILE

Parents - Married ☐ Separated ☐ Divorced ☐

Mother's Name: _____

D.O.B.: _____ Highest school grade: _____

Occupation: _____ Employer: _____

Health: _____

Father's Name: _____

D.O.B.: _____ Highest school grade: _____

Occupation: _____ Employer: _____

Health: _____

SIBLINGS

List child's brothers and sisters:

Name:	D.O.B.
1. _____	_____
Health: _____	
2. _____	_____
Health: _____	
3. _____	_____
Health: _____	
4. _____	_____
Health: _____	
5. _____	_____
Health: _____	
6. _____	_____
Health: _____	

Have any of your children died? ☐ Y ☐ N

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems - use abbrev. *(F)* Father, *(M)* Mother, *(B)* Brother, *(S)* Sister, *(MM)* Mother's Mother, *(MF)* Mother's Father, *(FM)* Father's Mother, *(FF)* Father's Father, *(A)* Aunt, *(U)* Uncle, *(C)* Cousin

- Anemia/Blood Dis _____
- Asthma/Allergies _____
- Mental Retardation _____
- Drug Problem _____
- Alcoholism _____
- Cancer _____
- Sudden Infant Death _____
- Cystic Fibrosis _____
- Musc. Dystrophy _____
- Tuberculosis _____
- Arthritis/Lupus _____
- Epilepsy/Seizures _____
- Early Diabetes _____
- Early Deafness _____
- Birth Defects _____
- AIDS _____
- High Blood Pressure _____
- High Cholesterol _____
- Migraines _____
- Heart Disease _____
- Kidney Disease _____
- Emotional Problems _____
- Thyroid Disease _____
- Inherited Disease _____
- Other _____

(over)

SAFETY/ENVIRONMENT

1. Do you live in a ☐ private house, ☐ apartment, ☐ mobile home, ☐ other?
2. Do you know the hottest temperature of the water in your pipes? ☐ Y ☐ N
3. Is there a working smoke alarm on each floor in the house? ☐ Y ☐ N
4. Does your child always use a car seat/ seatbelt when riding a car? ☐ Y ☐ N
5. Are there any smokers in the household? ☐ Y ☐ N
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) ☐ Y ☐ N
7. Does your child always wear a helmet when riding his/her bicycle? ☐ Y ☐ N
8. Are there firearms in your home? ☐ Y ☐ N

DEVELOPMENT & BEHAVIOR

Age at which child:

Sat alone_____ Walked_____ Used sentences_____

Toilet trained_____ Bicycled_____

Development compared to other children?_____

_____

Grade in school_____ Problems in school? ☐ Y ☐ N

Learning problems? ☐ Y ☐ N_____

Getting along with other children? ☐ Y ☐ N_____

Behavior problems ☐ Y ☐ N _____

_____

Bad habits?_____ Bedwetting? ☐ Y ☐ N

Nail biting? ☐ Y ☐ N Problems sleeping? ☐ Y ☐ N

Hobbies - sport - social activities? _____

_____

Use of street or illegal drugs? ☐ Y ☐ N

Other mental health problems: _____

_____

_____

Are there any particular problems or stresses for your family now such as marriage difficulties, job/financial problems, family illness, problems with other children?

_____

_____

_____

_____

_____

_____

_____

I hereby give my permission for my child to receive medical care in the case of an emergency in the event I can't be reached.

_____ _____

Date Signature of Parent or Legal Guardian