Pediatric Patient Questionnaire

Reason For Today's Visit: _____

Previous Medical Care: Dr. _____ ☐ Dental Care _____ ☐ Eye Exam _____

PREGNANCY AND BIRTH

Mother's age at pregnancy? _____

☐ Yes ☐ No Any illness during pregnancy? _____

☐ Yes ☐ No Medications during pregnancy (exclude vitamins & iron)? _____

☐ Yes ☐ No Medications during pregnancy? _____

During Pregnancy: ☐ Smoking ☐ Alcohol ☐ Street drugs _____

Was baby: ☐ Early ☐ On time Any Complications? _____

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

Problems with baby at birth? ☐ Breathing ☐ Jaundice ☐ Other: _____

Problems soon after? ☐ Yes ☐ No Nursery or home? _____

PAST MEDICAL HISTORY

Allergic Reactions? ☐ Medicine ☐ Food ☐ Animals ☐ Insect bites ☐ Other: _____

Medications taken on a regular basis (exclude vitamins)? _____

Are Immunizations up to date? ☐ Yes ☐ No | Do you have a record? ☐ Yes ☐ No

Hospitalizations (when-where-why)? _____

Serious Injuries (when-where)? _____

Please check all that apply:

☐ Measles
☐ Mumps
☐ German (3-day) Measles
☐ Chicken Pox
☐ Whopping Cough
☐ Rheumatic Fever
☐ Scarlet Fever

Recurrent Infect? (3 or more):
☐ Ear ☐ Throat
☐ Asthma/Wheezing
☐ Eczema/Hives
☐ Seizures
☐ Bleeding tendency
☐ Anemia

☐ Hepatitis

Problems with:
☐ Hearing ☐ Vision

☐ Blood transfusions

Other: _____

_____

_____

FEEDING AND NUTRITION

Food Allergies: ☐ Yes ☐ No If yes, explain _____

Appetite usually good? ☐ Yes ☐ No | Colic or feeding problems during first 3 months? ☐ Yes ☐ No

☐ Breast feed? Number of months: _____ ☐ Formula? Current brand: _____

Vitamins? ☐ Yes ☐ No If yes, what brand _____ Fluoride: ☐ Yes ☐ No

Special diet? ☐ Yes ☐ No If yes, explain: _____

PT. LABEL (REQUIRED ON PAGE 1 ONLY)

FAMILY PROFILE

Parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other: _____

Mother's Information

_____ ____ _____ _____

Name Age Highest education level Health status

_____ _____ _____

Home Number Work Number Cell Number

Father's Information

_____ ____ _____ _____

Name Age Highest education level Health status

_____ _____ _____

Home Number Work Number Cell Number

Please list child's brothers and sisters and their ages:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

FAMILY MEDICAL HISTORY - List all blood relatives of your child who have had the following problems – Circle abbreviations: [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 Disorder	F	M	B	S	MM	MF	FM	FF	A	U	C	**Arthritis**	F	M	B	S	MM	MF	FM	FF	A	U	C
Asthma	F	M	B	S	MM	MF	FM	FF	A	U	C	**Epilepsy/Seizures**	F	M	B	S	MM	MF	FM	FF	A	U	C
Mental Retardation	F	M	B	S	MM	MF	FM	FF	A	U	C	**Heart Disease**	F	M	B	S	MM	MF	FM	FF	A	U	C
Drug Problem	F	M	B	S	MM	MF	FM	FF	A	U	C	**High Blood Pressure**	F	M	B	S	MM	MF	FM	FF	A	U	C
Alcoholism	F	M	B	S	MM	MF	FM	FF	A	U	C	**Cholesterol Problem**	F	M	B	S	MM	MF	FM	FF	A	U	C
Cancer	F	M	B	S	MM	MF	FM	FF	A	U	C	**Migraine**	F	M	B	S	MM	MF	FM	FF	A	U	C
Aids	F	M	B	S	MM	MF	FM	FF	A	U	C	**Sudden Infant Death**	F	M	B	S	MM	MF	FM	FF	A	U	C
Cystic Fibrosis	F	M	B	S	MM	MF	FM	FF	A	U	C	**Birth Defects**	F	M	B	S	MM	MF	FM	FF	A	U	C
Musc. Dystrophy	F	M	B	S	MM	MF	FM	FF	A	U	C	**Early Deafness**	F	M	B	S	MM	MF	FM	FF	A	U	C
Tuberculosis	F	M	B	S	MM	MF	FM	FF	A	U	C	**Diabetes**	F	M	B	S	MM	MF	FM	FF	A	U	C

DEVELOPMENT AND BEHAVIOR – Age at which child-

Sat alone: _____ Walked: _____ Used sentences: _____ Toilet trained: _____

Bicycled: _____ Development compared to other children? _____

Grade in school: _____ Problems in school? ☐ Yes ☐ No _____

Learning problems? _____

Getting along with other children? ☐ Yes ☐ No _____

Behavior problems? ☐ Yes ☐ No _____ Bad habits: _____

Bedwetting: ☐ Yes ☐ No | Nail biting: ☐ Yes ☐ No | Sleeping: ☐ Yes ☐ No

Hobbies, sports, social activities: _____

Use of street or illegal drugs? ☐ Yes ☐ No If yes, _____

PT. LABEL (REQUIRED ON PAGE 1 ONLY)