

Pediatric Health History Questionnaire (Birth- 12 years)

Date of 1st visit:

Name:	Date of Birth:	Age:	M	F
Parent 1:	Parent 2:			
Address:	City:	State:	Zip:	
Phone: (home)	(work)	(cell)		
Social Security Number:				
School:				
Parent 1 employer:		Parent 2 employer:		

Insurance

Insurance Company:	Phone:
Billing address:	
ID:	
Group:	
Policy holder:	Policy holder's date of birth:

How were you referred here? _____

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

What are your child's most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Allergies

Is your child intolerant or allergic to...

Any drugs? _____

Any foods? _____

Environmental? _____

Prenatal History

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth? _____

Mother's health during pregnancy?

- | | | |
|---------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Physical or emotional trauma | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Cigarettes, alcohol, drug consumption | |
| <input type="checkbox"/> Illnesses | <input type="checkbox"/> Medications | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes |

Birth History

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Blue baby |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Rashes |

Other (explain) _____

Medical History: Check if child has had,

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Tonsillitis, approx. #. _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ear infections, #. _____ |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> other (please list) _____ |

Injuries/Surgeries/Hospitalizations (please list): _____

Immunizations: Check if child has had the following immunizations,

- | | | | | |
|--------------------------------------|--------------------------------|----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio | <input type="checkbox"/> MMR | <input type="checkbox"/> PCV | <input type="checkbox"/> All standard for age |
| <input type="checkbox"/> HiB | <input type="checkbox"/> DPT | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Influenza | |

Others (list) _____

Any adverse reactions? Y N What? _____

Family History: Check if any immediate family member has had:

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Birth defects
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies	<input type="checkbox"/> Mental illness

Current State of Health

Feeding: Breast fed? ___ how long? _____ Formula? _____ milk / soy _____
Age began solids _____ Which foods first? _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

Medications

Prescription medications

- 1) _____
- 2) _____
- 3) _____

Over the counter medications

- 1) _____
- 2) _____
- 3) _____

Supplements and Vitamins

- 1) _____
- 2) _____
- 3) _____

Development

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

