**Pediatric Health History Questionnaire:**

# Child's name Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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) |

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| **Family History** |
| Relationship |  | Living Y/N | Age | Major Medical Problems and/or Cause of Death |
| Father’s Name |  |  |  |  |
| Mother’s Name |  |  |  |  |
| Siblings Names |  |  |  |  |
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| Specifically have any of the child's relatives had the following conditions |
| Condition | Relative |  | Condition | Relative |
| Diabetes |  | Kidney problems |  |
| Cancer |  | Heart disease |  |
| Seizures |  | Stroke |  |
| Allergies/asthma |  | Anemia |  |
| Bleeding problems |  | HIV |  |
| High blood pressure |  | Skin problems |  |
| Lung disease |  | Chemical dependency |  |
| Mental illness |  | Other: |  |
| Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare? |

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| **Newborn History** |
| Birth Weight: | Birth length: | Head Circumference: |
| Born on time?  Early  Late How much: |
| Type of delivery Vaginal 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 vomiting | Breathing trouble | Receive antibiotics |
| Jaundice (yellow skin) | Need of oxygen | Diarrhea |
| Cyanosis (blueness) | Blood transfusion | In intensive care unit |

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| **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: |

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| **Allergies** |
| Please list any allergies to medications or foods |
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| **Medications** |
| Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency |
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| **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 |
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# Parent Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_