

PEDIATRIC HEALTH QUESTIONNAIRE

Date _____ MRN _____

Patient Name _____ Date of Birth _____

Parent/Guardian Name: _____ Phone: _____

Prior physicians: _____

FAMILY HISTORY

PARENTS

Mother's Health Problems: _____

Father's Health Problems: _____

BROTHERS AND SISTERS Number of Brothers _____ Number of Sisters _____

Serious health problems or cause of death _____

Is there a history in your family of: (circle)

- | | | |
|---------------------|---------------------------------------|--------------------|
| Diabetes | High Blood Pressure | Breast Cancer |
| Bleeding Disorders | Ulcerative Colitis or Crohn's Disease | Ovarian Cancer |
| Asthma or Allergies | Heart Attack or Bypass before age 50 | Colon Cancer |
| Migraines | Inherited or genetic diseases | Prostate Cancer |
| | | Sickle Cell Anemia |

MEDICAL HISTORY

List any and all known medical problems:

List any and all surgeries or hospitalizations with approximate dates:

List all medications (including amount and doses per day) including over-the-counter medications, vitamins, herbs, supplements, etc:

List any medications you are allergic to:

Is the patient current on their immunizations? Yes No

Patient Name _____ MRN _____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING: (circle)

Chicken Pox	Heart Murmur	Psychiatric Problem	Radiation Treatment
Rheumatic Fever	Irregular Pulse	Seizure (epilepsy)	Reaction to bee stings
Pneumonia	Diabetes	Anemia (low blood count)	Easy bleeding
Hepatitis	High blood pressure	Concussion	Sickle Cell Anemia
Eczema	Fainting spell	Ulcer	Blood Transfusion
Cancer	High Cholesterol	Asthma	

PERINATAL HISTORY: (for children 5 and under only)

Number of pregnancies of mother: _____

Did the mother have any of the following during her pregnancy with this child: (circle)

Diabetes or sugar in urine	Protein in urine	High blood pressure	Bleeding
Medications taken	Infection	Preterm labor	
Smoking	Drinking	Drug use	

Was the child born within two weeks of the due date? Yes No

Vaginal birth? _____

C-section? _____ Reason for C-section? _____

Any complications with labor or delivery? _____

Did baby go home with mother? (circle) Yes No

Did the child have: (circle) Breathing problems Infection Jaundice Feeding problems

Birth weight? _____

Parent/Guardian Signature

Date