Pediatric Questionnaire

Child's name: _____ Date of Birth: _____ MRN#: _____

Family History

Mother's Age: _____ Height: _____ Weight: _____ Father's Age: _____ Height: _____ Weight: _____

Names of other children	Age	Sex	Health Problems

Did any children die? _____

Family Illnesses : Please write the name (mother, sister, uncle, etc.) of family members who have had these illnesses		
1.	Hay Fever, Allergies, Asthma	
2.	Birth Defects	
3.	Blood Disease (Hemophilia, Anemia, Leukemia)	
4.	Bone and Joint Disease	
5.	Cancer	
6.	Emphysema, Bronchitis, Cystic Fibrosis	
7.	Deafness	
8.	Blindness or Eye Problems	
9.	Convulsions, Seizures	
10.	Menatal Retardation	
11.	Mental Illness	
12..	Diabetes	
13.	Thyroid or Glandular Problems	
14.	Heart Disease (under 50)	
15.	Stroke	
16.	High Blood Pressure (under 50)	
17.	Kidney or Bladder Problems	
18.	Muscular Dystrophy	
19.	Rheumatic Fever, Rheumatic Heart Disease	
20.	Sudden Death	
21.	Still Births	
22.	Obesity	
23.	Short Stature, Tall Stature	
24.	Gallstones, Ulcers, Colitis	
25.	Learning Problems	

Prenatal History

Number of Pregnancies of Mother? _____ Number of Miscarriages: _____

Did the child's mother have any of the following during her pregnancy with this child? (please circle)

☐ Diabetes or Sugar in Urine ☐ High Blood Pressure ☐ Bleeding ☐ Smoking ☐ Drug Dependence

☐ Albumin (protein) in Urine ☐ Medications Taken ☐ Infection ☐ Drinking ☐ other _____

Was this child born: ☐ within 2 weeks of due date ☐ early ☐ late

How early did the child's mother seek pregnancy medical care? _____

Was the birth: ☐ Vaginal ☐ C-Section ☐ Breech (feet first) Any complications with the labor or pregnancy:

Did the child have:: ☐ Breathing Problems ☐ Infection ☐ Feeding Problems ☐ Jaundice

Did the baby go home with mother? _____ Birth weight: _____

Nutritional History

As an infant was the child: ☐ Breast Fed? (How long?): _____ ☐ Bottle Fed? (How long?) _____

Did any foods disagree with the child? _____

Does the child eat a variety of:

Fruits & Vegetables? ☐ Yes ☐ No Grains? ☐ Yes ☐ No

Dairy Products? ☐ Yes ☐ No Meats? ☐ Yes ☐ No

Supplements? (Vitamins, Iron, Fluoride) _____

Does the family drink: ☐ City Water ☐ Well Water

Development

At what age did the child: Smile? _____ Sit? _____ Walk? _____ Say Words? _____

Potty Training: Bowel? _____ Bladder (Day)? _____ Bladder (Night)? _____

Does the child have any problems in school? ☐ Yes ☐ No

If YES, please explain: _____

Is the child in a special class: ☐ Yes ☐ No

Emotional Development

Does the child have:

☐ Temper Tantrums ☐ Unreasonable Fears ☐ Head Banging ☐ Frequent Fights

☐ Excess Quietness ☐ Behavior Problems ☐ Depression ☐ Trouble with Police

☐ Excessive Activity ☐ Trouble Sleeping ☐ Rocking ☐ Drug/Alcohol Dependency

☐ Unusual Eating

General Health

Is this child taking any medication? ☐ Yes ☐ No

Is the child allergic to anything (medicine, pets, food)? _____

Has the child been out of the U.S. or Canada? ☐ Yes ☐ No When? _____ Where? _____

Operations: What? _____ When? _____

Major Illnesses: What? _____ When? _____

Hospitalizations: What? _____ When? _____

Has the child had any of the following?

☐ Measles	☐ German Measles	☐ Frequent Colds	☐ Frequent Headaches	☐ Tuberculosis
☐ Mumps	☐ Whooping Cough	☐ Frequent Diarrhea	☐ Tendency to Bleed	☐ Chicken Pox
☐ Anemia	☐ Frequent Constipation	☐ Cerebral Palsy	☐ Cystic Fibrosis	☐ Pneumonia
☐ Cancer	☐ Rheumatic Fever	☐ Cross or Lazy Eyes	☐ Glasses/Contact Lens	☐ Bronchitis
☐ Asthma	☐ Diabetes (sugar)	☐ Muscle Weakness	☐ Bone Disease	☐ Hearing Loss
☐ Eczema	☐ Kidney Disease	☐ Mental Retardation	☐ Heart Disease	☐ Reaction to Wasp/Bee Sting
☐ Soiling	☐ Bowel Disease	☐ Vaginal Bleeding	☐ Convulsions/Epilepsy	
☐ Hepatitis	☐ Stomach Aches	☐ Ear Infections	☐ Swollen Joints	
☐ Meningitis	☐ Eating of non-food items	☐ Bed Wetting past 5 yrs old	☐ Kidney or Bladder Infection	

Immunizations

Where obtained? _____ Is record available? ☐ Yes ☐ No

Home Environment

Number of people living in child's home: Children: _____ Adults: _____

Any pets? ☐ Yes ☐ No

Does the child spend a lot of time in a building where there is chipped or peeling paint? ☐ Yes ☐ No

Babysitting or Daycare arrangements: _____

With whom does the child live? ☐ Both parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Are you having any serious family problems? ☐ Yes ☐ No

Are there any problems you would like to discuss with us? ☐ Yes ☐ No

_____ _____ _____

Name of person completing this form | Relationship to child | Date