Date: _____

PEDIATRIC HISTORY QUESTIONNAIRE

Please answer these questions to help us with the care of your child.

Patient Name: _____

Date of Birth: _____

Name	Date of Birth	Occupation	Healthy?
Father:			
Mother:			
Siblings:			

Names of others living in the household: _____

Are the biological parents living together? Yes__ No __

Circle Yes/No or fill in the blanks.

1. Were there any problems, infections, or abnormal tests during pregnancy?	Yes	No
2. Was any treatment or medication required during pregnancy?	Yes	No
3. Mother's age at birth: _____		
4. Delivery method: Vaginal __ Cesarean: __		
5. Were there any difficulties during labor or delivery?	Yes	No
6. Were there any problems at birth, such as jaundice (yellow), breathing difficulty?	Yes	No
7. Was the baby premature?	Yes	No
If so, at how many weeks? _____		
8. Weight at birth: _____ lbs., _____ oz., or _____ kgs.		
9. Place of birth: _____		
10. Were there any problems during the first month of life?	Yes	No
11. Do you have any concerns about your child's development?	Yes	No
12. If in school, current grade: _____		
13. Has your child ever had chickenpox?	Yes	No
14. Has your child ever had to stay in the hospital?	Yes	No

If so, please list:

Date	Name of Hospital	Reason

15. Is your child allergic to any medications?	Yes	No
If so, please list: _____		
16. Is your child allergic to any foods?	Yes	No
If so, please list: _____		
17. Does your child take fluoride?	Yes	No
18. Does your child take vitamins?	Yes	No

Please check any of the following that your child has ever had.

- ( ) Skin conditions, eczema
- ( ) Eye problems, glasses
- ( ) Frequent ear infections
- ( ) Difficulty hearing
- ( ) Frequent nose bleeds
- ( ) Pneumonia
- ( ) Asthma or lung problems
- ( ) Heart murmur
- ( ) Jaundice
- ( ) Frequent stomach aches
- ( ) Frequent diarrhea
- ( ) Constipation
- ( ) Stitches
- ( ) Other: _____
- ( ) Kidney or bladder infections
- ( ) Difficulty urinating
- ( ) Bedwetting
- ( ) Problems with menstrual periods
- ( ) Anemia
- ( ) Head injuries
- ( ) Loss of consciousness
- ( ) Seizures
- ( ) Frequent headaches
- ( ) Migraines
- ( ) Trouble gaining weight
- ( ) Problems with muscles
- ( ) Broken bones

What interests, hobbies, or activities does your child do outside of school?

_____

_____

How many hours a day does your child watch TV? _____

Are there any financial, personal, or family problems you are worried about?

_____

How does your child do in school?

_____

Does s/he have good friends? _____

Please check any of the following conditions which relatives have had (parents, grandparents, siblings).

- ( ) Asthma
- ( ) Eczema
- ( ) Hayfever
- ( ) Tuberculosis
- ( ) High blood pressure
- ( ) Stroke
- ( ) Heart attack under age 55
- ( ) High cholesterol
- ( ) Thyroid or Goiter
- ( ) Deafness other than elderly
- ( ) Cataracts, glaucoma
- ( ) Astigmatism, amblyopia (lazy eye)
- ( ) Seizures
- ( ) Diabetes
- ( ) Obesity
- ( ) Migraines
- ( ) Learning disabilities
- ( ) Attention deficit disorder
- ( ) Hyperactivity
- ( ) Intestinal diseases, colitis
- ( ) Anemia or blood diseases
- ( ) Kidney disease or stones
- ( ) Cystic fibrosis
- ( ) Mental retardation
- ( ) Birth defects
- ( ) Neurological diseases
- ( ) Muscles diseases
- ( ) Mental health conditions
- ( ) Depression
- ( ) Schizophrenia
- ( ) Smoking
- ( ) Alcoholism
- ( ) Drug use
- ( ) Death before age 50
- ( ) Cancer
- ( ) Inherited or genetic diseases