



Pediatric Health Questionnaire  
Birth – 5 years

Please complete and return

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible; it will help your child to get the most from their visits. Mark anything that you do not understand with a question mark. Thank you.

Patient's name: \_\_\_\_\_ Date of first visit: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: female / male

Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Parent's relationship status:  Married  Separated  Divorced  Widowed  Single  Partnership

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact parent: \_\_\_\_\_

Parents Phone # (home): (\_\_\_\_) \_\_\_\_\_ (work): (\_\_\_\_) \_\_\_\_\_ (cell): (\_\_\_\_) \_\_\_\_\_

May we leave confidential voice-mail messages for you at any of the above numbers? No / Yes (specify): **Home / Work / Cell**

Parents e-mail address: \_\_\_\_\_

May we leave confidential E-mail messages for you at the above address? No / Yes

\_\_\_\_ (initials) I understand that it is possible if my child's personal health information is sent over email that it may be viewed by others. I recognize and accept this possibility and authorize my doctor to communicate facets of my child's personal health information with me over email.

How did you hear about our clinic? \_\_\_\_\_

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: \_\_\_\_\_

Reason for referral or presenting problems: \_\_\_\_\_

**MEDICATIONS**

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

**MEDICAL HISTORY**

_____ Chicken pox	_____ Scarlet fever	Tonsillitis, approx. no. _____
_____ Measles	_____ Pneumonia	Ear infections, no. _____
_____ Mumps	_____ Frequent colds	Other (please list) _____
_____ Rubella	_____ Rheumatic fever	



Has your child had any of the following tests?      When                      Where                      Results

Electroencephalogram                      .....

Psychological evaluation                      .....

Hearing                      .....

Speech/Language                      .....

Injuries/Surgeries/Hospitalizations (please list): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATIONS**

\_\_\_\_ Measles      \_\_\_\_ Polio      \_\_\_\_ MMR      \_\_\_\_ Smallpox      \_\_\_\_ Diphtheria

\_\_\_\_ Mumps      \_\_\_\_ DPT      \_\_\_\_ Tetanus      \_\_\_\_ Influenza

Others (list) \_\_\_\_\_

Any adverse reactions? Y N What ? \_\_\_\_\_

**FAMILY HISTORY**

Member	Age	Important diseases	Living?	Cause of death
Mother				
Father				
Siblings				
Siblings				
*MGM				
*MGF				
*PGM				
*PGF				

M = Maternal (Mother) P = Paternal (Father) GM = Grandmother GF = Grandfather

Any other relevant family history? \_\_\_\_\_

\_\_\_\_\_

What is your child's ethnic background? \_\_\_\_\_

**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) \_\_\_\_\_

Child's sleep patterns (first year) \_\_\_\_\_

Food intolerances (if any) \_\_\_\_\_

Feeding: Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula? \_\_\_\_\_ milk / soy / other \_\_\_\_\_

Age began solids \_\_\_\_\_ Which foods? \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

**SYMPTOMS** (mark **Y** if current, **P** if significant past symptom)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hives          | <input type="checkbox"/> Burning of urine   | <input type="checkbox"/> Bloody urine        |
| <input type="checkbox"/> Eczema         | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cries easily        |
| <input type="checkbox"/> Bleeding gums  | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Nervous             |
| <input type="checkbox"/> Nose bleeds    | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Sleep problems      |
| <input type="checkbox"/> Acne           | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Night sweats        |
| <input type="checkbox"/> High fevers    | <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Sensitive to light  |
| <input type="checkbox"/> Chronic rash   | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Body/breath odor    |
| <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Easy bruising      | <input type="checkbox"/> Motion/car sickness |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Flat feet          | <input type="checkbox"/> No appetite         |
| <input type="checkbox"/> Sore throats   | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Nightmares          |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Gas                | <input type="checkbox"/> Canker sores        |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Unusual fears       |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Joint pains        | <input type="checkbox"/> Excessive fatigue   |
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Dizzy spells       | <input type="checkbox"/> Hair loss           |



**DIET**

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

**Done. Thank you for your time and effort. We look forward to helping your child in any way we can.**