



Name: _____

Date of Birth: _____

Medical Record #: _____

Pediatric History Questionnaire

Family Member	Name	Birth Date	Healthy?
Father			
Mother			
Brothers			
Sisters			
Others living in household			

Are natural parents living together? _____ If not, please explain. _____

Growth & Development

Was pregnancy normal or difficult? If difficult, please explain. _____

Was delivery normal or difficult? If difficult, please explain. _____

Birth Weight: _____ Was the baby full term? ____ If not, how many weeks early? _____

Did your baby have any problems in the nursery? ____ If yes, please describe: _____

At what age did child:

Walk without help?		Toilet trained?	
Talk (two words together)?		Stay dry at night?	

Hospitalizations, major illnesses, and Injuries

Age	Problem	Hospitalized?

Are there any problems that concern you about your child right now? _____

(OVER)

Any allergies to food or medication? ____ If yes, please list and explain reaction. _____

List medications and dosages child is presently taking, including vitamins and supplements: _____

Review of Symptoms: Indicate which of the following conditions or problems your child has *recently* had:

<input type="checkbox"/> Eye problems	<input type="checkbox"/> Acne	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Eczema	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Rashes	<input type="checkbox"/> Constipation
<input type="checkbox"/> Frequent ear infections		
<input type="checkbox"/> Difficulty hearing	<input type="checkbox"/> Kidney/Bladder infection	<input type="checkbox"/> Headaches
<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Seizures
<input type="checkbox"/> Frequent sore throats		<input type="checkbox"/> Learning difficulties
	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Behavioral problems
<input type="checkbox"/> Asthma or bronchitis	<input type="checkbox"/> Sexually active	<input type="checkbox"/> Weight issues

Social History:

What does child do in spare time? _____

How much times does child spend watching TV, play video games, or use computer _____

How is he/she doing in school? _____

Does he/she have good friends? _____

Indicate any financial, interpersonal, or family problems you are worried about. _____

Family History: Indicate conditions which close relatives (parents, siblings, & grandparents) have:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Migraine	<input type="checkbox"/> Obesity
<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Cholesterol
	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eczema	<input type="checkbox"/> Psychiatric disorders	Other:
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	

Date Completed

Reviewed by: (MD, NP, PA)