



**NEW PATIENT**

**Pediatric Health History Questionnaire:**

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

**Pregnancy and Birth History**

Mother's age at birth: _____		Father's age at birth: _____	
Did mother have any of the following during pregnancy?			
Yes No Fever or rash	Yes No Tobacco use (how much)		
Yes No Group B strep	Yes No Alcohol use (how much)		
Yes No Sugar in urine / diabetes	Yes No Street drug use (what type)		
Yes No Anemia	Yes No High blood pressure		
Yes No Medication use (prescription & over-the-counter - list)	Yes No Infections (what type and how were they treated)		

**Newborn History**

Birth Weight: _____	Birth length: _____	Head Circumference: _____
Born on time / early / late?	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section (why): _____	Days in Hospital: _____
During the first week of life did the patient have any of the following?		
Yes No Feeding trouble	Yes No Seizures	Yes No Fever
Yes No Excess vomiting	Yes No Breathing trouble	Yes No Receive antibiotics
Yes No Jaundice (yellow skin)	Yes No Need of oxygen	Yes No Diarrhea
Yes No Cyanosis (blueness)	Yes No Blood transfusion	Yes No In intensive care unit

**Family History**

Relationship	Name	Living	Age	Major Medical Problems and/or Cause of Death
Father		Yes No		
Mother		Yes No		
Siblings		Yes No		
If more than 3 siblings continue on back		Yes No		
		Yes No		

Specifically have any of the child's relatives had the following conditions?

Condition	Relative	Condition	Relative
Yes No Diabetes		Yes No Kidney problems	
Yes No Cancer		Yes No Heart disease	
Yes No Seizures		Yes No Stroke	
Yes No Allergies / asthma		Yes No Anemia	
Yes No Bleeding problems		Yes No HIV or immunodeficiency	
Yes No High blood pressure		Yes No Skin problems	
Yes No Lung disease		Yes No Chemical dependency	
Yes No Mental illness (Anxiety, Depression, ADHD)		Yes No Congenital Malformation or Syndrome	
Yes No Drug or Alcohol abuse		Yes No Other	

Are there any religious or cultural factors we should take into account in planning your child's healthcare? Yes No

### Past Medical History

Where has child gone for check-ups previously:

Date of last medical check-up:

Date of last dental check-up:

Is your child up-to-date on immunizations (please provide certificate)? Yes No

Has your child had any of the following?

Yes No Chicken pox

Yes No Wears glasses

Yes No Asthma

Yes No Measles

Yes No Heart murmur

Yes No Kidney or bladder infection

Yes No Mumps

Yes No Allergies

Yes No Frequent ear infections (> 4 year)

Yes No Broken bones

Yes No Head injury

Yes No Bed wetting (> 5 years old)

Yes No Seizures

Yes No Diabetes

Yes No Frequent throat infection (> 4 year)

Yes No Hearing Problems

Yes No Fatigue

Yes No Skin problems (Eczema, hives)

Yes No Psychological Problems

Yes No Anemia

Yes No Muscle / Joint problems

Has your child had any other medical conditions? (Please list) Yes No

Has your child ever been hospitalized or had surgery? Yes No

If yes, list age and reason:

Do you have any concerns about your child's development? Yes No

If yes, please describe:

### Child's Social Characteristics

School Grade / Preschool:

City Water: Yes No

Hours of TV / Electronics Each Day:

Exposure to Second Hand Smoke: Yes No

Special Diet:

Guns in Home: Yes No

Weekly Hours of Outdoor Activity:

Wears Sunscreen: Yes No

Pets:

Wears Seatbelt / Car Seat / Booster: Yes No

Sports / Hobbies:

Special Communication Needs: Yes No

### Allergies

Does your child have any allergies to medications or foods and environmental allergies? (list) Yes No

### Medications

Does your child take any medications, including over the counter medications, herbs, vitamins and supplements?  
(list and include dosage and frequency) Yes No

### Specialty Providers

Has your child seen any medical providers outside of this practice, currently or in the past?  
(list provider and approximate date last seen) Yes No

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_