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?	☐ Vaginal ☐ 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: _____