In order for us to serve you better, please take a few moments to complete this form. Thank you.

PEDIATRIC PATIENT QUESTIONNAIRE

DATE _____ PCP _____ MR# _____

Name _____ Birthdate _____ Sex: M ☐ F ☐

Mother _____ Birthdate _____ Phone _____

Address _____

Father _____ Birthdate _____ Phone _____

Address _____

Legal Guardian (if other than parent) _____ Phone _____

Address _____

Siblings (names & birthdates) _____

_____

Parents are: Married_____ Single_____ Separated_____ Divorced_____

Members of Household _____

_____

Pets in the home _____ Smokers in the home _____

Well water or city Water _____ Any home built prior to 1950/lead exposure _____

Diet _____ Daycare _____

ALLERGIES (drugs, food, pollens, etc.) _____

FAMILY HISTORY

Do any of the child's close relatives (mother, father, grandparents, brother or sister) have any of the following? (Please list relative)

_____ Diabetes	_____ Cancer	_____ Allergic Disease	_____ Seizures
_____ Heart Disease	_____ Bleeding Disorders	_____ Asthma	_____ Kidney Disease
_____ High Blood Pressure	_____ Sickle Cell Trait	_____ Cystic Fibrosis	_____ Alcoholism
_____ High Cholesterol	_____ Depression	_____ Tuberculosis	_____ Depression/Mental Illness

BIRTH HISTORY

Length of Pregnancy _____ Complications _____

Type of Delivery _____ APGAR Scores _____/_____ Weight _____ Length _____

Complications during labor or delivery _____

Problems in the nursery _____

Type & length of feeding (breast/formula) _____ Type of formula _____

DID THE CHILD HAVE ANY OF THE FOLLOWING PROBLEMS DURING THE FIRST FEW MONTHS OF LIFE?

☐ Jaundice	☐ Anemia	☐ Breathing difficulty	☐ Other (please list)
☐ Trouble feeding	☐ Seizures	☐ Blue spells	_____
☐ Severe colic	☐ Infections	☐ Required oxygen	_____

DEVELOPMENT At what age did the child first:

Gain head control_____ Sit alone_____ Speak single words_____
Roll over_____ Stand with support_____ Group words into sentences_____
Crawl_____ Walk alone_____

CHILDHOOD ILLNESSES Has the child had any of the following? (Check & list date)

_____ Chicken pox _____ Whooping cough/pertussis _____ Meningitis
_____ Tonsillectomy _____ Wheezing/asthma _____ Seizure
_____ Tubes placed in ears _____ Pneumonia _____ Ear infections
_____ Mumps _____ Heart murmur

HOSPITALIZATION/OPERATIONS/ACCIDENTS/INJURIES

_____

_____

_____

_____

MEDICATIONS

(List name, dosage, times per day. Include vitamins, flouride, iron, and non-prescription drugs.)

_____

_____

_____

HAS THE CHILD RECENTLY HAD ANY OF THE FOLLOWING? **(CIRCLE)**

Headaches
Trouble with eyes
Trouble with vision
Trouble with ears
Trouble with hearing
Frequent colds
Frequent sore throat
Cough
Shortness of breath/wheezing
Swollen glands
Nosebleeds
Skin rashes
Significant weight gain or loss
Change in appetite
Nausea
Vomiting
Diarrhea
Constipation
Unusual pain in abdomen
Difficulty with urination
Frequent urination or thirst
Weakness or fatigue
Swollen or painful joints
Other problems _____

DOES THE CHILD HAVE ANY UNUSUAL PROBLEM WITH: **(CIRCLE)**

Behavior/discipline
Trouble in school
Learning difficulty
Attention deficit
Hyperactivity
Irritability
Temper tantrums
Breath holding
Speech
Thumb sucking
Nightmares
Bedwetting
Toilet training

FOR GIRLS:

Age of first menstrual period _____ Date Reviewed with Patient_____
Date of last period _____ PCP Signature_____