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

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

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

FOR GIRLS:

Age of first menstrual period _____ Date Reviewed with Patient_____

Date of last period _____ PCP Signature_____