

### PEDIATRIC QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: F / M Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Employment: \_\_\_\_\_ Employment: \_\_\_\_\_

Name and relationship of people living at home: \_\_\_\_\_

Last Well Child Check (Date & Location): \_\_\_\_\_ Last Dental Visit: \_\_\_\_\_

Siblings (List Name and Birth date)	Health Problems
_____	_____
_____	_____
_____	_____

#### Child's History

Allergies: Y/N \_\_\_\_\_

Meds: Y/N \_\_\_\_\_

Surgeries: \_\_\_\_\_

Serious Illness/Injury: \_\_\_\_\_

Hospitalization: \_\_\_\_\_

Problems with immunizations: \_\_\_\_\_

Other problems? \_\_\_\_\_

#### Has Child Ever Had:

- difficulty with sight? Y / N
- difficulty with hearing? Y / N
- problems with ear infections? Y / N
- asthma? Y / N
- heart murmur? Y / N
- diabetes? Y / N
- seizures? Y / N
- pneumonia? Y / N
- urine infections? Y / N
- insect or food allergies? Y / N
- low blood count? Y / N
- chicken pox? Y / N

Describe Yes' from above: \_\_\_\_\_

#### Pregnancy History

Mom's Age at Birth \_\_\_\_\_

How many pregnancies? \_\_\_\_\_

List miscarriages, abortions, stillborns: \_\_\_\_\_

Weight Gain during pregnancy: \_\_\_\_\_

#### Did mom have any:

- serious illness? Y/N
- alcohol intake? Y/N
- prenatal care? Y/N
- drugs or marijuana? Y/N
- high blood pressure? Y/N
- urine protein? Y/N
- tobacco? Y/N

Describe Yes' from above: \_\_\_\_\_

How many weeks when prenatal care started? \_\_\_\_\_

#### Neonatal History

Birth Weight: \_\_\_\_\_

Vaginal or C-Section: \_\_\_\_\_

If C-Section list reason: \_\_\_\_\_

Hospital: \_\_\_\_\_

Due Date: \_\_\_\_\_

Actual Birth Date: \_\_\_\_\_

- Difficulties Breathing: Y/N
- Did child go home with mom? Y/N
- Any IV's or Oxygen in the hospital? Y/N
- Any problems with Jaundice? Y/N
- Did mom stay > 2 days? Y/N
- Did baby take any medicines at hospital? Y/N

Describe Yes' from above: \_\_\_\_\_

## Family History

(Please include parents, siblings, aunts, uncles, and grandparents)

Asthma No Yes \_\_\_\_\_  
Allergies No Yes \_\_\_\_\_  
Lung Disease No Yes \_\_\_\_\_  
Tuberculosis No Yes \_\_\_\_\_  
Smoking No Yes \_\_\_\_\_  
Heart Attack/Heart Disease/Stroke in < 55 y/o  
No Yes \_\_\_\_\_  
Heart Attack/Heart Disease/Stroke in > 55 y/o  
No Yes \_\_\_\_\_  
High Blood Pressure No Yes \_\_\_\_\_  
Heart Defects/Murmur No Yes \_\_\_\_\_  
High Cholesterol No Yes \_\_\_\_\_  
Diabetes I (child) No Yes \_\_\_\_\_  
Diabetes II (adult onset) No Yes \_\_\_\_\_  
Obesity No Yes \_\_\_\_\_  
Vision Problems No Yes \_\_\_\_\_  
Glaucoma/Cataracts No Yes \_\_\_\_\_  
Retinoblastoma No Yes \_\_\_\_\_  
Anemia No Yes \_\_\_\_\_  
Sickle Cell No Yes \_\_\_\_\_

Other: \_\_\_\_\_

Cancer No Yes \_\_\_\_\_  
Cancer Treatment No Yes \_\_\_\_\_  
Kidney Problems No Yes \_\_\_\_\_  
Intestinal Disease No Yes \_\_\_\_\_  
Eating Disorders No Yes \_\_\_\_\_  
Sudden Death (children)/SIDS  
No Yes \_\_\_\_\_  
Birth Defects No Yes \_\_\_\_\_  
Mental Retardation No Yes \_\_\_\_\_  
Other Mental Illness No Yes \_\_\_\_\_  
Nervous Breakdown No Yes \_\_\_\_\_  
Learning Disability No Yes \_\_\_\_\_  
ADHD No Yes \_\_\_\_\_  
Depression No Yes \_\_\_\_\_  
Suicide No Yes \_\_\_\_\_  
Alcohol/Drug Abuse No Yes \_\_\_\_\_  
Seizure No Yes \_\_\_\_\_  
Muscular Diseases No Yes \_\_\_\_\_  
Childhood Deafness No Yes \_\_\_\_\_  
Thyroid Disease No Yes \_\_\_\_\_  
Inherited Illnesses No Yes \_\_\_\_\_  
AIDS No Yes \_\_\_\_\_

## Behavior and Development

Age of Child when first... sat alone: \_\_\_\_\_

walked alone: \_\_\_\_\_

By 18 months could child speak any words?

Y/N

Does child's development compare to same age children?

Y/N

### Do you have concerns about:

vision Y/N  
hearing Y/N  
eating Y/N  
speech Y/N  
sleep Y/N  
behavior Y/N  
bed-wetting Y/N  
toilet training Y/N  
colic Y/N  
constipation/diarrhea Y/N  
thumb sucking/nail biting Y/N  
anxiety/depression Y/N  
School or daycare problems Y/N  
Other: \_\_\_\_\_

Describe Yes' from above: \_\_\_\_\_