Pediatric History Questionnaire

Patient Name _____ Birth date _____

Form Completed By _____ Chart Number _____

Date _____ Nurse Initials _____

Household

Please list everyone living in the child's home.

Name	Relationship to Child	DOB	Health Problems

Birth History

Birth weight _____

How many weeks gestation? _____

Was initial feeding ☐ Breast ☐ Bottle

Did mother have any problem with her pregnancy?

☐ Yes ☐ No Explain _____

During pregnancy, did mother:

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No What _____ When _____

Was the delivery ☐ Vaginal ☐ C-section

If C-section, why? _____

Breech position/birth ☐ Yes ☐ No

Did the baby have any problems right after birth?

☐ Yes ☐ No Explain _____

Was the baby in the NICU? ☐ Yes ☐ No

Did the baby have breathing problems? ☐ Yes ☐ No

Did the baby have jaundice issues? ☐ Yes ☐ No

Did your baby go home with mother from hospital?

☐ Yes ☐ No Explain _____

General

Do you consider your child to be in poor health? ☐ Yes ☐ No Explain _____

Does your child have a serious medical condition? ☐ Yes ☐ No Explain _____

Has your child had significant injuries/accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medications? ☐ Yes ☐ No Explain _____

Does your child take any regular medications? ☐ Yes ☐ No Explain _____

Development

When did your child: Sit up _____ mos. Crawl _____ mos. Walk _____ mos. First sentence _____ Toilet trained _____

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

How is your child's behavior in school? _____

Has he/she failed or repeated a grade? _____

What kind of grades does he/she make in academic subjects? _____

Is he/she in a special or resource classes? _____

Family History

Have family members (Patient's mother, father, sister, brother, aunt, uncle, grandfather, grandmother) had the following:

Significant allergies ☐ Yes ☐ No Who/Explain _____

Asthma ☐ Yes ☐ No Who/Explain _____

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Deafness	☐ Yes	☐ No	Who/Explain	_____
Tuberculosis	☐ Yes	☐ No	Who/Explain	_____
Heart disease (onset before age 50 yrs.)	☐ Yes	☐ No	Who/Explain	_____
High blood pressure (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain	_____
Stroke (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain	_____
Diabetes (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain	_____
High cholesterol	☐ Yes	☐ No	Who/Explain	_____
Bleeding disorders	☐ Yes	☐ No	Who/Explain	_____
GI disorders (Celiac, IBS, UC, Crohn's)	☐ Yes	☐ No	Who/Explain	_____
Cancer	☐ Yes	☐ No	Who/Explain	_____
Autoimmune disorders	☐ Yes	☐ No	Who/Explain	_____
Liver disease	☐ Yes	☐ No	Who/Explain	_____
Convulsions or seizures	☐ Yes	☐ No	Who/Explain	_____
Migraine	☐ Yes	☐ No	Who/Explain	_____
ADHD/learning disability	☐ Yes	☐ No	Who/Explain	_____
Mental illness/suicide	☐ Yes	☐ No	Who/Explain	_____
Intellectual disability?	☐ Yes	☐ No	Who/Explain	_____
Immune deficiency/HIV/AIDS	☐ Yes	☐ No	Who/Explain	_____
Orthopedic problems(arthritis, rheumatoid arthritis, scoliosis)	☐ Yes	☐ No	Who/Explain	_____
Pediatric Hip Disorders	☐ Yes	☐ No	Who/Explain	_____

Review of Systems

Does your child have, or has he/she ever had: (If "Yes" please explain)

Chickenpox	☐ Yes	☐ No	Explain	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Allergies	☐ Yes	☐ No	Explain	_____
Problem with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, wheezing, bronchiolitis	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Severe abdominal pain	☐ Yes	☐ No	Explain	_____
Recurrent vomiting	☐ Yes	☐ No	Explain	_____
Chronic diarrhea	☐ Yes	☐ No	Explain	_____
Constipation requiring office visits	☐ Yes	☐ No	Explain	_____
Bladder, kidney or urinary tract infections	☐ Yes	☐ No	Explain	_____
Bed-wetting after 5 years old	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual period?	☐ Yes	☐ No	If yes, when was her last menstrual cycle?	_____
(For girls) Are there any problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurring skin problems	☐ Yes	☐ No	Explain	_____
Severe headache	☐ Yes	☐ No	Explain	_____
Convulsions, seizures, or concussions	☐ Yes	☐ No	Explain	_____
Thyroid or gland problem	☐ Yes	☐ No	Explain	_____

☐ Updated _____ Initials _____ ☐ Updated _____ Initials _____ ☐ Updated _____ Initials _____

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