

PEDIATRIC HEALTH QUESTIONNAIRE

NAME: _____ **DATE:** _____ **AGE:** _____

BIRTH HISTORY:

DATE OF BIRTH: _____

BIRTH WEIGHT: _____ **FULL TERM** _____ **YES** _____ **NO**

IF NO, EXPLAIN _____

MEDICAL PROBLEMS OF PREGNANCY

_____ **Vaginal Bleeding**

_____ **High Blood Pressure**

_____ **Diabetes**

_____ **Twin or Multiple Births**

_____ **Toxemia or Seizures**

_____ **Infections, Including Bladder, Kidney, Herpes, Gonorrhea, Syphilis, German Measles, CMV**

DELIVERY: _____ **Vaginal** _____ **C-Section**

If C-Section, give reason: _____

NURSERY COURSE

_____ **Normal**

_____ **Jaundice**

_____ **Oxygen Therapy**

_____ **Other**

PAST MEDICAL HISTORY

Hospitalizations: Give dates and reason: _____

Surgery: _____

Serious accidents or injuries: _____

Allergies: _____

Chronic or frequently recurring illnesses: _____

Medications (including any over the counter medicine used regularly): _____

Are immunizations up to date: _____ YES _____ NO

FAMILY HISTORY

Father: Name _____ Age: _____

Occupation: _____ Health: _____

Mother: Name _____ Age: _____

Occupation: _____ Health: _____

Marital Status: _____

**If remarried due to death or divorce, with whom does this child live? _____

FULL SIBLINGS

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Half Siblings

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Please list any other people living in household with this child: _____

Has anyone in this child's family had any of the following problems?

YES	NO		YES	NO	
_____	_____	Alcoholism/Drug Addiction	_____	_____	Heart Attack (Coronary)
_____	_____	Bleeding Problem	_____	_____	High BP (Hypertension)
_____	_____	Cancer/Tumors	_____	_____	Kidney Problems
_____	_____	Deafness	_____	_____	Mental Retardation
_____	_____	Diabetes (Sugar)	_____	_____	Nervous Disorder
_____	_____	Epilepsy (Fits, Seizures)	_____	_____	Sickle Cell Anemia
_____	_____	Tuberculosis (TB)	_____	_____	Suicide

Please list any other illnesses which runs in this child's family: _____

REVIEW OF SYSTEMS

HAS THIS CHILD HAD ANY OF THE FOLLOWING:

YES	NO	
_____	_____	significant health problems during the past year
_____	_____	any unexplained weight loss or fail to gain weight
_____	_____	bad vision problems or difficulty recognizing colors
_____	_____	speech, hearing, ear or throat problems
_____	_____	frequent colds or runny noses
_____	_____	convulsion, seizure or fit
_____	_____	foot problems
_____	_____	heart murmur or heart problems
_____	_____	wheezing or difficulty breathing or any other respiratory problem
_____	_____	frequent stomach aches, vomiting or digestive problems
_____	_____	frequent constipation or diarrhea
_____	_____	bladder, kidney or urine infection, bed wetting or any other urinary problem
_____	_____	unusual bruising or bleeding

SOCIAL HISTORY

Water supply: _____ Well _____ City

Is water fluorinated? _____ YES _____ NO

Any smokers in the home? _____ YES _____ NO

****FOR ADOLESCENT GIRLS ONLY****

YES NO HAS THIS CHILD HAD:

_____ any unusual vaginal odor discharge

_____ any problems related to puberty

_____ started having menstrual periods. If yes, at what age did periods begin? _____

_____ Does she understand reproduction and contraception?

****FOR ADOLESCENT BOYS ONLY****

YES NO

_____ Has this child had any problems related to puberty?

_____ Does he know how to perform testicular self-exam?

Please list any additional problems or special concerns about this child's health which you would like to discuss. _____
