PEDIATRIC HEALTH QUESTIONAIRE

NAME: ________________________________ **DATE:** ______________ **AGE:** ________

BIRTH HISTORY

DATE OF BIRTH: ______________________ BIRTH WEIGHT: __________________

FULL TERM: YES ____ NO ____ IF NO EXPLAIN: ______________________________

____

MEDICAL PROBLEMS OF PREGNANCY

_____ Vaginal bleeding

_____ Diabetes

_____ Toxemia or seizures

_____ High blood pressure

_____ Twin or multiple births

_____ 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: ____

Previous hospitalizations, Give dates and reason:

____

____

Previous surgery:

____

____

PLEASE CHECK ALL THAT APPLY:

	MOTHER	FATHER	GRANDPARENT	SIBLING
Alcohol/Drug abuse	________	________	________________	_________
Allergies	________	________	________________	_________
Anemia	________	________	________________	_________
Asthma	________	________	________________	_________
Birth Defect	________	________	________________	_________
Bleeding Disorder	________	________	________________	_________
Cancer	________	________	________________	_________
Deafness	________	________	________________	_________
Diabetes (Type)	________	________	________________	_________
Epilepsy	________	________	________________	_________
Heart Disease	________	________	________________	_________
High Blood Pressure	________	________	________________	_________
High Cholesterol	________	________	________________	_________
Immune Problems	________	________	________________	_________
Kidney Problems	________	________	________________	_________
Liver Problems	________	________	________________	_________
Mental Illness	________	________	________________	_________
Sickle Cell	________	________	________________	_________
Stroke	________	________	________________	_________
Tuberculosis	________	________	________________	_________

If other, please specify: ____

____

____

Does anyone in the home smoke? Yes No

Is the child in daycare? Yes No

Siblings? Please list:

Name: ______________________________ Age: ____________________

Name: ______________________________ Age: ____________________

Name: ______________________________ Age: ____________________

Name: ______________________________ Age: ____________________

Name: ______________________________ Age: ____________________

Are patient's parents: ________ Married

________ Divorced

________ Never Married

Are there any **chronic illnesses** for this child? (example asthma)

____

List all medications this child takes:

Prescription: ____

____

Over the counter: ____

____

Allergies: ____

*** Children over 14 years of age *** Please allow your child to answer: DO YOU SMOKE? ______________________________________