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

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 ______________

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

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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Condition	Yes	No	Who/Explain
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)

Condition	Yes	No	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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HIGHLAND AVENUE
PRIMARY CARE

Pediatric History Questionnaire

805830 R 10/12/2018

Name / MR # / Label