PEDIATRIC HEALTH QUESTIONAIRE

NAME:_____DATE:_____CURRENT AGE_____

1. **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:_____

A. **HOSPITALIZATIONS: Give Date(s) and Reason:**_____

_____

_____

_____

_____

B. **SURGERY:**_____

_____

_____

PLEASE CHECK ALL THAT APPLY:

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

If other, please specify:_____

Does anyone in the home smoke? CIRCLE YES NO

Is the child in Daycare? CIRCLE 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? (ex: allergies/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_____

General Information

PHARMACY

Name:_____

Address:_____

City:_____

Telephone Number:_____

SPECIFIC INFORMATION TO YOUR CHILD

Please circle

We need your childs race: Asian, Black, Chinese, Filipino, Hispanic, Japanese, Native American, Native Hawaiian, White, Undetermined, Patient Refusal

We need your choice of language: Chinese, English, French, Italian, Spanish, Vietnamese, Patient Refusal

We need your childs ethnicity: Caucasian, Hispanic, Not Hispanic, Patient Refusal

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION BEFORE YOUR ARRIVAL TO OUR SCHEDULED VISIT!