

Pediatric Health Information Questionnaire

Patient name: _____ Date: ____/____/____

Date of birth: _____ Age: _____ New patient Established patient

General Information

Who is completing this health form? _____

What is your relationship to the patient? _____

What is your preferred language for health care information? _____

What is the best way for the office to contact you? Phone Email Text Other

What is your preferred method of communication? Verbal Sign language Written Nonverbal Other

Interpreter required? Yes No

Does the patient have any disabilities or health limitations (e.g. blindness/hearing impairment)? Yes No

If yes, please list: _____

Allergies

Is the patient allergic to any medications? Yes No If yes, please list: _____

Medications

List all medications the patient takes on regular basis (include over-the-counter, herbal or natural remedies)

Birth History

Pregnancy:

Medical problems? Yes No If yes, please list. _____

Hospital: _____

Pregnancy complications:

None Gestational diabetes Fewer than three prenatal visits Multiple gestation

Pregnancy induced hypertension Placental abruption Placenta previa Rh Sensitization

Maternal substance use during pregnancy:

Smoking Alcohol use Medications Recreational drugs Other

Delivery:

Normal Prolonged Difficult Vaginal C/Section Breech VBAC Other

Newborn:

Full term Premature If premature, by how many weeks? _____

Date of birth _____ Time of birth _____ Birth weight _____



Pediatric Health Information Questionnaire

Birth History

Newborn complications:

- Feeding problems
 Jaundice
 Breathing problems
 Fever
 Anemia
 Glucose problems
 Antibiotic therapy
 NICU admission
 Other
 Group B strep

Newborn leaving hospital:

Discharge date: ___/___/___ Discharge weight _____ Problems in nursery? Yes No

PKU before discharge? Yes No Date: ___/___/___ Time: _____

Feeding:

Formula? Yes No If yes, formula type? _____

Breast? Yes No If yes, how long? _____

Medical illnesses or conditions (list any chronic conditions the patient has been diagnosed with):

Family History

Please indicate if the patient's blood relative(s) have had/currently have the following:

	Father	Mother	Grandparents	Aunt/Uncle	Siblings
Allergies					
Immunodeficiency					
Drug problems					
SIDS					
Birth defects					
Developmental delay					
Blindness					
Deafness					
Cystic fibrosis					
Muscular dystrophy					
Cancer					
Ulcer/heartburn					
Blood disease					

	Father	Mother	Grandparents	Aunt/Uncle	Siblings
Sickle cell disease					
Diabetes					
Hepatitis					
Tuberculosis					
Asthma					
High cholesterol					
Heart disease					
High blood pressure					
Kidney or bladder problems					
Seizures/convulsions					
Migraine					
Sudden death in family younger than age 55					

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History/Hospitalizations/Medical Devices

Please list any surgery or procedure and the year it was performed:

Please list any hospitalizations and the year they occurred:

Has the patient ever had a transfusion? Yes No

If yes, did the patient have a reaction or problem with the transfusion? Yes No

Social History

Does the patient smoke? Yes No Does anyone smoke at home? Yes No

Does the patient drink alcohol? Yes No Is there alcohol abuse in your household? Yes No

Does the patient use drugs? Yes No Is there substance abuse in the patient's household? Yes No

Is the patient currently in school/daycare? Yes No If yes, what is the patient's grade level? _____

Does the patient have school concerns? Yes No

If yes, check the patient's concern. Learning Social Communication Health Cultural Other? _____

Does the patient regularly exercise? Yes No Times per week: 1 to 2 3 to 4 5 to 6 Daily

Tell us about the patient's nutrition/health: _____

Does the patient eat a healthy diet? Yes No Is the patient on a special diet? Yes No

If yes, please explain _____

What is the patient's appetite level? Good Fair Poor Does the patient take vitamins/supplements? Yes No

If yes, please list: _____

Tell us about the patient's home environment.

House Apartment Other Single parent

Who lives in the household with the child? Mother Father Siblings Others (Please list) _____

Does the patient feel safe at home? Yes No If no, does the patient have a safe place to go? Yes No

Are there situations of injury/abuse/neglect in the patient's household? Yes No

Have agencies/others been notified? Yes No Does the patient have family/friends available to help? Yes No

Is there a concern for family members at home? Yes No Does the patient have any sleeping problems? Yes No

Does the patient use alternative healthcare? Yes No Is the patient sexually active? Yes No

Pediatric Health Information Questionnaire

Systems Review

Please indicate items that have been ongoing or a recent significant change.

Yes No

General

- Excessive colic
- Fatigue/lethargy
- Fever
- Unexplained weight loss

Eyes

- Drainage/discharge
- Glasses/contacts
- Redness or watering
- Styes
- Vision concerns
- Eye crossing

Ears

- Difficulty hearing
- Ear drainage
- Ear pain
- Frequent infections
- Hearing concerns

Nose/Sinuses

- Chronic runny nose
- Nose bleeds
- Nasal stuffiness
- Sinus trouble

Mouth/throat

- Dental defects
- Sore throat
- Large tonsils

Cardiovascular

- Murmur
- High cholesterol
- Chest pain
- Excessive fatigue with exercise

Psychiatric

- Attention problems
- Depression
- Moodiness
- Sleep disturbances

Yes No

Musculoskeletal

- Broken bones
- Hip problems
- Joint swelling
- Back pain
- Joint pain
- Muscle aches

Skin

- Dry skin
- Moles/birthmarks
- Pale skin color
- Recurrent rashes
- Jaundice
- Eczema

Respiratory

- Chronic cough
- Difficulty breathing
- Hoarseness
- Wheezing
- Apnea/breath holding
- Trouble breathing with exercise

Allergic/immunologic

- Frequent infection
- Recurrent hives
- Sneezing
- Hay fever

Gastrointestinal

- Abdominal pain
- Blood in stool
- Constipation
- Nausea/vomiting
- Vomiting blood
- Feeding difficulties

Genitourinary

- Abnormal discharge
- Blood in urine
- Pain urinating
- Burning
- Bed wetting/incontinence
- Frequent urination

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Systems Review

Please indicate items that have been ongoing or a recent significant change.

Yes No

Blood/lymph

- Anemia
- Easy bruising
- Excessive bleeding
- Large lymph nodes

Neurological

- Seizures/convulsions
- Tremor
- Weakness/paralysis
- Limb paralysis
- Dizziness
- Fainting spells
- Migraine
- Frequent headaches

Endocrine

- Excessive eating
- Excessive drinking
- Cold intolerance
- Heat intolerance

Yes No

Reproductive (flex for by gender)

Female:

Date of last period: _____

- Vaginal discharge
- Vaginal itching/burning
- Irregular periods
- Painful periods
- Spotting between periods

Male:

- Swelling of the scrotal sac/testes
- Testicular pain
- Penile discharge

Comments: _____
