

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

To be completed for children 12 years and younger

Today's date: _____

Name: _____
DOB: _____ Age: _____
HT: _____ WT: _____ SEX: M or F
RT hand dominant or LT hand dominant

Pediatrician: _____
Requesting Dr: _____

ALLERGIES & ADVERSE DRUG REACTIONS

Please circle if allergic:
Shellfish Iodine Xray dye Eggs Poultry Soy

Feathers Latex Nickel Tape
Other: _____

HOSPITALIZATIONS:

Please list condition, year, and hospital

SURGICAL HISTORY:

Please list procedure, year, and hospital

Any reaction to anesthesia: Yes No
Please explain: _____

FEMALE PATIENTS ONLY:

Have you started menstruation? Yes or No
Age _____
Do you take medication to regulate your period? Yes No
Are you pregnant? Yes No

PRESCRIPTION MEDICATIONS:

MEDICATION	DOSE
_____	_____
_____	_____

SOCIAL HISTORY:
School: _____ Grade _____
Sports/Exercise _____
Hobbies: _____

Smoker: Yes NO, if yes, # of packs p/day _____
Exposed to second hand smoke? Yes No
Is there alcohol use in the home? Yes No
Does patient or family member use
any recreational drugs? Yes No

FAMILY HISTORY:

Please state who and details
Arthritis _____
Cancer _____
Diabetes _____
Heart problems _____
Stroke _____
High blood pressure _____
Thyroid disease _____
Blood clots/diseases _____
Club feet _____
Congenital hip dislocation _____
Epilepsy _____
Hepatitis _____
Nervous disorder _____
Scoliosis _____
Tuberculosis _____
Malignant hyperthermia _____
Other diseases _____

BIRTH HISTORY

Mother ill during pregnancy? Yes or No _____
Mother had xrays during pregnancy? Yes or No
Mother took medication during pregnancy? Yes or No
Child born: Vaginally or cesarean
Child born: Head first or breech
Full term pregnancy (37-40 wks) Yes or No
Child's birth weight _____
Is child a twin? Yes or NO – If yes, Identical or Not

DIRECTIONS/SIG	REASON/INDICATION
_____	_____
_____	_____

PAST MEDICAL HISTORY:

Please circle and comment

- Anemia Yes or No _____
- Anxiety Yes or No _____
- Asthma Yes or No _____
- Back disorder Yes or No _____
- Blood clots/disease Yes or No _____
- Blood in urine Yes or No _____
- Cancer Yes or No _____
- Change in BMs Yes or No _____
- Colitis or IBS Yes or No _____
- Coughing up blood Yes or No _____
- Depression Yes or No _____
- Diabetes Yes or No _____
- Emphysema Yes or No _____
- Epilepsy/Seizures Yes or No _____
- Gallbladder disease Yes or No _____
- Gout Yes or No _____
- Fainting Yes or No _____
- HIV/AIDS Yes or No _____
- Heart disease Yes or No _____
- Chest pain Yes or No _____
- Heart failure/CHF Yes or No _____
- Irregular heart beat Yes or No _____
- Hepatitis/liver dis Yes or No _____
- High blood pressure Yes or No _____
- High cholesterol Yes or No _____
- Kidney disease Yes or No _____
- Lung disease Yes or No _____
- Mental disease Yes or No _____
- MRSA/serious inf. Yes or No _____
- Neuropathy Yes or No _____
- Prostate problems Yes or No _____
- Rectal bleeding Yes or No _____
- Shortness of breath Yes or No _____
- Stroke Yes or No _____
- Swollen/pain joints Yes or No _____
- Thyroid disease Yes or No _____
- Ulcers Yes or No _____
- Venereal dis/STD Yes or No _____
- Rheumatoid disease Yes or No _____
- Wounds that not
healed properly Yes or No _____
- Other _____

REVIEW OF SYSTEMS:

Musculoskeletal:

- Spina Bifida/mobility impairment Yes or No
- Muscular Dystrophy Yes or No
- Auto-Immune Disorder Yes or No
- Fractures _____ Yes or No
- Back pain Yes or No
- Joint pain Yes or No

Neurological:

- Stroke/Mini Stroke Yes or No
- Epilepsy Yes or No
- Seizures Yes or No
- Migraine headaches Yes or No
- Hydrocephalus/Shunt Yes or No
- Cerebral Palsy Yes or No
- Dizziness Yes or No
- Paralysis Yes or No
- Fainting Yes or No

Cardiac:

- Heart problems/murmur Yes or No
- High Blood Pressure Yes or No
- Irregular heartbeats Yes or No
- Blood clots Yes or No
- Chest pain/pressure Yes or No

Pulmonary:

- Asthma Yes or No
- Pneumonia Yes or No
- Sleep Apnea Yes or No
- Oxygen Use Yes or No
- Tuberculosis Yes or No
- RSV Yes or No
- Shortness of breath Yes or No
- Wheezing Yes or No
- Cough Yes or No

GI:

- GERD/reflux Yes or No
- Hepatitis Yes or No
- Liver disease Yes or No
- Jaundice Yes or No
- Abdominal pain Yes or No
- Blood in stool Yes or No
- Change in bowel movements Yes or No
- Constipation Yes or No
- Diarrhea Yes or No
- Vomited blood Yes or No

REVIEW OF SYSTEMS CONT'D

Eyes:

Double/blurred vision Yes or No

Ears/Nose/Throat/Mouth:

Hoarseness Yes or No

Nosebleeds Yes or No

Difficulty swallowing Yes or No

Hem/Oncology:

Bleeding disorder Yes or No

Anemia Yes or No

Cancer Yes or No

AIDS/HIV Yes or No

Endocrine:

Diabetes Yes or No

Metabolic disorder Yes or No

GU:

Kidney disease Yes or No

Bladder infections Yes or No

Decreased urine Yes or No

Pus in urine Yes or No

Pain while urinating Yes or No

Phyisc:

Behavioral problems Yes or No

Anxiety Yes or No

Depression/worry Yes or No

IMMUNIZATIONS UP TO DATE? Yes or No

(Complete only for children under age 5)

At birth did the baby have:

Cyanosis (blueness) Yes or No

Breathing problems Yes or No

Jaundice (yellowness) Yes or No

Feeding problems Yes or No

Other problems _____

Has your child gained weight well? Yes or No

Has your child had any serious illness? Yes or No

If yes, please explain: _____

PLEASE FILL IN THE AGE OF YOUR CHILD WHEN HE/SHE WAS ABLE TO DO THE ACTIVITY OR CIRCLE "DOES NOT" (Complete only for children under age 5)

My child sat alone at _____ months. Does not

My child stood alone at ____ months. Does not

My child walked alone at _____months. Does not

My child said his first word at ____months. Does not

My child talked in sentences at ____months. Does not

My child was toilet trained at _____months. Does not

My child is able to feed him/herself since _____ years. Does not

My child dressed him/herself since _____ years. Does not

I HAVE READ AND ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

Parent signature (or guardian for minor)

Today's date

Physician's signature

Today's date

Clinical Assistant/Reviewer Initials:

