

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: _____

**MEDICATIONS & DOSAGES INCLUDING
OVER THE COUNTER AND SUPPLEMENTS**

HOSPITALIZATIONS:

Please list condition, year, and hospital

SURGICAL HISTORY:

Please list procedure, year, and hospital

Any reaction to anesthesia: Yes No

Please explain: _____

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

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

PLEASE COMPLETE BOTH SIDES

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:

