

# PEDIATRIC PATIENT QUESTIONNAIRE

## PEDIATRIC - HISTORY SHEET

Child's Name \_\_\_\_\_ Child's Birth date \_\_\_\_\_ Date Child First Seen \_\_\_\_\_  
Child's Father \_\_\_\_\_ Child's Mother \_\_\_\_\_ Child's Sex \_\_\_\_\_ Child's Race \_\_\_\_\_

Child's Brothers/Sisters \_\_\_\_\_

Child's Birth weight \_\_\_\_\_  
Child's head circ. \_\_\_\_\_

Child's Birth length \_\_\_\_\_

Doctor delivering child \_\_\_\_\_ Hospital child born in \_\_\_\_\_  
Was your baby: Breast fed \_\_\_\_\_ bottle fed \_\_\_\_\_ formula name \_\_\_\_\_  
Type of Delivery \_\_\_ Vaginal \_\_\_ C-section

## PREGNANCY HISTORY

	Yes	No		Yes	No
1. Smoking	_____	_____	5. Bleeding	_____	_____
2. Alcoholic Beverages	_____	_____	6. Toxemia	_____	_____
3. Infections	_____	_____	7. High Blood Pressure	_____	_____
4. Medication/Drugs	_____	_____	8. Premature Labor	_____	_____
			9. Other	_____	_____

## PROBLEMS WITH NEWBORN

	Yes	No		Yes	No
1. Jaundice	_____	_____	4. Breathing problems	_____	_____
2. Infections	_____	_____	5. Feeding problems	_____	_____
3. Colic	_____	_____	6. Other _____	_____	_____

Other \_\_\_\_\_  
At what age did your child: sit up \_\_\_\_\_ crawl \_\_\_\_\_ walk \_\_\_\_\_

## FAMILY HISTORY

	Yes	No
1. Diabetes	_____	_____
2. Asthma	_____	_____
3. Cancer	_____	_____
4. Cystic fibrosis	_____	_____
5. Muscular dystrophy	_____	_____
6. Heart disease	_____	_____
7. High blood pressure	_____	_____
8. Sickle cell	_____	_____
9. Anesthetic reaction	_____	_____
10. Bleeding disorder	_____	_____
11. Thyroid disease	_____	_____
12. Other _____	_____	_____

## CHILD'S ALLERGIES

List All Medication Allergies \_\_\_\_\_

Present Medications \_\_\_\_\_

Other Allergies

**SIGNIFICANT ILLNESSES/INJURIES**

Hospitalized  
Yes No

\_\_\_\_\_

\_\_\_\_\_

**CHILD'S MEDICAL HISTORY**

	Yes	No	
1. Eye Surgery	_____	_____	_____
2. Glasses	_____	_____	_____
3. Tonsillitis	_____	_____	_____
4. Ear infections	_____	_____	_____
5. Ear tubes	_____	_____	_____
6. Frequent "colds"	_____	_____	_____
7. Asthma	_____	_____	_____
8. Chronic cough	_____	_____	_____
9. Pneumonia	_____	_____	_____
10. Heart disease	_____	_____	_____
11. Heart murmur	_____	_____	_____
12. Chronic skin rashes	_____	_____	_____
13. Thyroid disorder	_____	_____	_____
14. Diabetes	_____	_____	_____
15. Stomach pain	_____	_____	_____
16. Chronic constipation	_____	_____	_____
17. Chronic diarrhea	_____	_____	_____
18. Hepatitis	_____	_____	_____
19. Kidney/bladder infections	_____	_____	_____
20. Bedwetting over age 3	_____	_____	_____
21. Anemia	_____	_____	_____
22. Headaches	_____	_____	_____
23. Swollen or painful joints	_____	_____	_____
24. Chronic muscle aches	_____	_____	_____
25. Seizure disorder	_____	_____	_____
26. Behavior disorder	_____	_____	_____
27. Learning disorder	_____	_____	_____
28. Other	_____	_____	_____

**CHILD CARE OUTSIDE THE HOME (explain)** \_\_\_\_\_

**TESTS & IMMUNIZATIONS** (Give date last done)

(Give date last done)	Yes	Mo/Yr		Yes	Mo/Yr
1. Chest x-ray	_____	_____	10. DPT, Dose 1	_____	_____
2. CBC	_____	_____	11. DPT, Dose 2	_____	_____
3. Fasting Blood Sugar	_____	_____	12. DPT, Dose 3	_____	_____
4. Thyroid Profile	_____	_____	13. DPT, Dose 4	_____	_____
5. Hearing Test	_____	_____	14. DPT, Dose 5	_____	_____
6. Vision Test	_____	_____	15. Polio, Dose 1	_____	_____
7. Blood Profile	_____	_____	16. Polio, Dose 2	_____	_____
8. Urine Test	_____	_____	17. Polio, Dose 3	_____	_____
Other _____	_____	_____	18. Polio, Dose 4	_____	_____
Other _____	_____	_____	19. MMR	_____	_____
Other _____	_____	_____	20. TB	_____	_____

**GIRLS ONLY**

Menstrual periods: Age of onset \_\_\_\_\_ Date of last period \_\_\_\_\_

Periods are: (circle one) regular irregular Difficulty with periods? (Circle one) Yes No