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PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION Today's Date_____

Last Name _____(MI)_____First_____

Date of Birth_____ SSN# _____

Address_____
Street Address City State Zip Code

Home Phone _____ Cell Phone _____

E-mail Address _____

How did you find us? _____

EMERGENCY CONTACT NAME AND INFORMATION

Name of person to contact in case of an emergency_____

Contact's home phone_____Contact's cell phone_____

Primary Care Physician

Current Medications:

Immunizations up to date? Yes No	If not, what is missing?

Reason for today's visit:

Past Medical History
Please list any prior major illnesses:

Birth History: Any problems with the pregnancy?	Yes	No
Was your child born full term?	Yes	No (If no, how early?)
Medical problems at birth?	Yes	No
Was your child on a ventilator?	Yes	No (If yes, how long?)
Was your child jaundiced? If yes, was transfusion needed?	Yes	No

Hospitalization:
Except at birth, has your child been hospitalized? Yes No
If yes, list age(s) and reason:
_____
_____
_____
_____

Surgery*:*
Has your child ever had surgery? Yes No
If yes, list age(s), and reason:
_____
_____
_____

Review of Systems

Does your child have or has your child ever had (if yes, please explain):

	Circle One		If Yes, please explain:
General*:*			
Fever	Yes	No	_____
Poor weight gain/weight loss	Yes	No	_____
Problems with nutrition	Yes	No	_____
Difficulty feeding	Yes	No	_____
Chicken pox	Yes	No	_____
Genetic disorders	Yes	No	_____
Ear, Nose, and Throat:			
Ear Infections (Otitis Media)	Yes	No	_____

Age at 1st ear infection: _____
Number of infections in the past 6 months: _____
Number of courses of antibiotics in past 6 months: _____
When last clear of middle ear fluid: _____
Concern with possible hearing loss? Yes No _____

Concern that speech development…

…may not be age appropriate? Yes No _____
Balance disturbance? Yes No _____
Nosebleeds? Yes No _____
Nasal congestion? Yes No _____
Sinus infections? Yes No _____
Number of sinus infections in past 6 months: _____
With each infection, usual number of days symptomatic prior to starting antibiotic therapy: _____
Recurrent tonsillitis? Yes No _____
Number of episodes strep (+) tonsillitis in the past year: _____
Number of episodes the year before, and the year before that: _____

Difficulty sleeping at night?	Yes	No	_____
Snoring:	Yes	No	_____
If yes: loud and obstructive	Yes	No	_____
Retractions/working to breathe	Yes	No	_____
Bedwetting	Yes	No	_____
Mouth Breathing	Yes	No	_____
Excessive daytime tiredness	Yes	No	_____
Hyperactivity	Yes	No	_____
Difficulty chewing/ swallowing?	Yes	No	_____
Is nasal regurgitation a problem when eating?	Yes	No	_____
Eyes:			
Wear glasses	Yes	No	Date of last exam _____
Infections	Yes	No	_____
Injuries	Yes	No	_____
Other problems	Yes	No	_____
Neurological:			
Headaches	Yes	No	_____
Seizure disorder	Yes	No	_____
Developmental delay	Yes	No	_____
Poor gross motor development	Yes	No	_____
Cerebral palsy	Yes	No	_____
Cardiovascular:			
Congenital heart abnormality	Yes	No	_____
Heart murmur	Yes	No	_____
Respiratory:			
Asthma/ reactive airway disease	Yes	No	
Bronchopulmonary dysplasia	Yes	No	_____
Noisy breathing	Yes	No	_____
Shortness of breath	Yes	No	_____
Cough	Yes	No	_____
Bronchitis	Yes	No	_____
Pneumonia	Yes	No	_____

Allergic/Immunologic:

Environmental allergy	Yes	No
Food allergy	Yes	No_____
Immunologic disorder	Yes	No _____
Previous allergy testing If yes, when? _____	Yes	No

List any positives _____

_____

_____

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Gastrointestinal:

Gastroesophageal reflux Yes No

If yes, age at diagnosis: _____

Diagnostic tests used: _____

Treatment given: _____

Recurrent spitting up/ vomiting	Yes	No
Frequent reswallowing	Yes	No
Irritability after feedings	Yes	No
Change in bowel habits	Yes	No

Endocrine:

Diabetes	Yes	No
Thyroid abnormalities	Yes	No
Other hormonal abnormalities	Yes	No

Bleeding Disorders:

Has your child ever had surgery, stitches for trauma or a broken bone?	Yes	No
If yes, was there more bleeding than expected during or after?	Yes	No
Does you child bruise more easily than normal?	Yes	No
If a boy and circumcised, was bleeding more than expected after the circumcision?	Yes	No
Was there bleeding when the umbilical cord came off?	Yes	No
Has your child had frequent nosebleeds?	Yes	No
Has your child bled more than normal after loss of baby teeth?	Yes	No
Is your child taking aspirin or ibuprofen products?	Yes	No
If an older girl, is there a history of heavy menstrual periods?	Yes	No
Has your child ever needed a blood transfusion for prolonged bleeding?	Yes	No
Do any blood relatives have an inherited bleeding problem such as Hemophilia, von Willebrand, or low platelets?	Yes	No
Has any blood relative been called a free bleeder?	Yes	No

Hematologic/ Lymphatic

Anemia Yes No _____

Persistent Swollen Glands or Lymph Nodes Yes No _____
Blood Transfusion Yes No _____
If Yes: at what age_____and why:
_____
_____

Musculoskeletal:

Broken Bones	Yes	No
Developmental abnormalities	Yes	No
Poor control of arms/legs	Yes	No

Genitourinary:

Urinary Tract Infections	Yes	No
Other abnormalities	Yes	No

Integumentary:

Eczema	Yes	No
Recurrent Rashes	Yes	No
Other skin abnormalities	Yes	No

Psychiatric:

Any psychiatric abnormalities	Yes	No

Family History

Is your child Adopted? Yes No
If yes, please fill out what information may be known about the birth family:

Are there any family members with:

	Circle One		If Yes, please explain:
Cleft lip/palate or other craniofacial abnormalities	Yes	No	_____ _____ _____
Childhood onset hearing loss not associated with ear infections	Yes	No	_____ _____ _____
Immune disorders			_____
Malignant Hyperthermia	Yes	No	_____
Other problems with anesthesia	Yes	No	_____
Other significant illnesses in the family:	Yes	No	_____
	Yes	No	_____ _____

If yes please list as follows:

Family Member	*List significant illnesses*
_____	_____
_____	_____
_____	_____

Social History:

Your child lives at home with:

Mother	Yes	No	_____
Father	Yes	No	_____
Siblings	Yes	No	#Brothers: #Sisters:
Foster Care	Yes	No	_____
Pets	Yes	No	_____
Does anyone smoke at home?	Yes	No	_____
Is your child in Daycare?	Yes	No	If yes, how many days per week?_____

How many kids in your child's room? _____ How many in daycare? _____

Is your child in school? Yes No What grade? _____

Number of days per week? _____

The above information is accurate to the best of my knowledge.

X

Signature of Parent or Guardian Date

_____

Relationship to Patient

For Physician Use **Only:**

I have reviewed the above information with the patient.

_____ _____

Physician Name & Signature Date