PEDIATRIC –PATIENT QUESTIONNAIRE DATE:_____

Completed by _____Relation_____

(Please check yes or no, circle or explain where required. N/A-not applicable)

Patient Name: _____DOB_____Sex____

Reason for today's visit_____

PREGNANCY & BIRTH:

Pregnancy Illness/Complications? No/ Yes _____Mother's age_____

Medications during pregnancy?_____

Smoking/Alcohol or street drugs? No/Yes_____ Delivery? Vaginal/C-Section

Birth Weight_____ Hospital _____

Apgar scores?_____ Full term? _____ Problems with baby at birth? Jaundice___Breathing__

Other_____

FEEDING AND NUTRITION

Feeding problems? _____

Breast fed? Yes/No- If yes, how many months?_____

Formula Brand? _____

FAMILY PROFILE

Parents married? Yes/No Separated? Yes/No Divorced? Yes/No

Father's age? _____ Good Health? _____

Mother's age?_____ Good Health? _____

List Siblings:_____

PAST MEDICAL HISTORY: (if not a newborn)

*Allergic Reactions? Medication No/Yes _____

Food No/Yes_____ Animals or Environmental No/Yes_____

Medications taken on a regular basis?_____

Immunizations up to date? Yes/No Hospitalizations or Surgeries?_____

_____

DEVELOPMENT AND BEHAVIOR

Age at which child –

Sat alone _____ Walked _____ Used Sentences _____ Potty Trained _____ Bicycled _____

Learning problems? _____ Bedwetting? _____

Problems in school? _____

PATIENT AND FAMILY HISTORY-PLEASE BE SPECIFIC WITH FAMILY MEMBER

Mother(m), Father(f),mothers mother(mm),mothers father(mf),fathers mother(fm),fathers father(ff)

Condition	Patient	Family	Condition	Patient	Family
Anemia			Diabetes		
Kidney/Urinary			Autism		
Liver Disease			Vision/Eye problems		
ADHD			Asthma		
Seizures			Immune Disorder		
Genetic Disease			Headaches/Migraine		
Lung Condition			High Blood Pressure		
Hearing Loss			Heart Disease		
Cancer			Depression		
Alcoholism			Drug Abuse		
Gastrointestinal			Cholesterol		

Other: _____