Pediatric Health History Questionnaire

Your answers on this form will help us understand your child's medical concerns and conditions.
ALL QUESTIONS ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____

SOCIAL HISTORY

Please list everyone living in the child's home including name and relationship to patient:

Does the child live with both biological parents? ☐ Yes ☐ No

If not, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family ☐ Foster Care

☐ Other family members: _____

Does anyone smoke at home? ☐ Yes ☐ No

Does your child attend school or daycare? If so, name/grade _____

BIRTH HISTORY

Baby's Birth Weight _____

☐ Full-term ☐ Preterm ____ weeks ☐ Post-term ____ weeks

Delivery: ☐ Vaginal ☐ Cesarean Reason: _____

Any complications during birth or after birth? ☐ No ☐ Yes Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)? ☐ No ☐ Yes Explain: _____

MEDICAL HISTORY

List Medication Allergies or Reactions: If no allergies check ☐ NONE

Medication Allergy	Reaction
1.	
2.	
3.	

Please list any surgeries or overnight hospital stays:

Type of surgery/reason for hospitalization	Reason	Date or Approx Year
1.		
2.		
3.		

Please check to indicate if your child has ever had the following conditions:

☐ Cataracts or retinoblastoma	☐ Eczema
☐ Vision impairment	☐ Thyroid problems
☐ Asthma	☐ Diabetes
☐ Nasal allergies (dust, pets, or environmental)	☐ Anemia or bleeding problems
☐ Hearing loss or concerns	☐ Cancer or chemotherapy
☐ Multiple cavities or problems with teeth	☐ Blood transfusion
☐ Heart murmur or other heart problems	☐ HIV or AIDS
☐ High blood pressure	☐ Developmental delays (speech or motor)
☐ Food allergies	☐ School problems or learning difficulties
☐ Feeding difficulty or underweight	☐ ADHD or behavioral concerns
☐ Overweight or obesity	☐ Anxiety
☐ Kidney, ureter, or bladder problems	☐ Depression
☐ Bone, joint, or muscle problems	☐ Tobacco, alcohol, or drug use
☐ Concussion or head injury	☐ Exposure to family violence
☐ Seizures	☐ Sexually transmitted infections

Females only:

Does your child have menstrual periods? ☐ Yes ☐ No

If yes: Age periods started _____ First day of last period_____

List all medications your child is currently taking.

Include vitamins, supplements and medications including prescriptions, inhalers, and over-the-counter drugs.

Medication Name	Strength	Frequency Taken
1.		
2.		
3.		

Preferred Pharmacy: _____

FAMILY HISTORY

Check any diseases that run in your family:

	Mother	Father	Sister	Brother	Grandmother (maternal)	Grandfather (maternal)	Grandmother (paternal)	Grandfather (paternal)	Other
Alcoholism/Drug Use									
Arthritis									
Depression									
Diabetes									
Cancer *type: _____									
Genetic Disease									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Obesity									
Stroke									
Thyroid Disease									