

**PEDIATRIC PATIENT QUESTIONNAIRE**

Completed by: \_\_\_\_\_

Relation: \_\_\_\_\_

Please check yes or no, circle or ??? where required. N/A-Not Applicable

Previous medical care — Dr. \_\_\_\_\_

Dental Care:  YES  NO

**PREGNANCY & BIRTH**

Mother's age at pregnancy? \_\_\_\_\_

Any illness during pregnancy?  YES  NO

Medications during pregnancy?  YES  NO

(exclude vitamins & iron)

Smoking — alcohol — street drugs — during pregnancy?

Was baby early — late — on time?

Type of delivery? \_\_\_\_\_

Birth weight: \_\_\_\_\_

Length: \_\_\_\_\_

Complications?  YES  NO

Apgar: \_\_\_\_\_

Problems with baby at birth? Breathing  YES  NO Jaundice:  YES  NO

Other \_\_\_\_\_

Problems soon after? Nursery or home? \_\_\_\_\_

**PAST MEDICAL HISTORY**

Allergic reactions? \_\_\_\_\_ Medicine:  YES  NO

Food:  YES  NO Animals:  YES  NO Insect Bites:  YES  NO

Medications taken on a regular basis? (exclude vitamins)

Immunizations — up to date?  YES  NO Do you have record?  YES  NO

Hospitalizations — (when-where-why?) \_\_\_\_\_

Serious injuries (when-where?) \_\_\_\_\_

	YES	NO		YES	NO		YES	NO
Red Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (3 day)	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	strep Throat	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Hives	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>	Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

**FEEDING & NUTRITION**

Food Allergies \_\_\_\_\_

Appetite usually good?  YES  NO

Colic or feeding problems during the first 3 months  YES  NO

Breast Fed?  YES  NO Number of months? \_\_\_\_\_

Formula?  YES  NO Current brand? \_\_\_\_\_

Vitamins  YES  NO Brand? \_\_\_\_\_ Fluoride?  YES  NO

**FAMILY PROFILE**

Parents  MARRIED  SEPARATED  DIVORCED

Father's age? \_\_\_\_\_ Highest school grade? \_\_\_\_\_ Health? \_\_\_\_\_

Mother's age? \_\_\_\_\_ Highest school grade? \_\_\_\_\_ Health? \_\_\_\_\_

(List child's brothers, sisters & their ages)

**FAMILY MEDICAL HISTORY**

List all blood relatives of your child who have had the following problems — use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin.

Anemia/Blood Dis \_\_\_\_\_

Asthma \_\_\_\_\_

Mental Retardation \_\_\_\_\_

Drug Problem \_\_\_\_\_

Alcoholism \_\_\_\_\_

Cancer \_\_\_\_\_

Aids \_\_\_\_\_

Cystic Fibrosis \_\_\_\_\_

Musc. Dystrophy \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Arthritis \_\_\_\_\_

Epilepsy / Seizures \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Cholesterol Problem \_\_\_\_\_

Migraine \_\_\_\_\_

Sudden Infant Death \_\_\_\_\_

Birth defects \_\_\_\_\_

Early Deafness \_\_\_\_\_

Diabetes \_\_\_\_\_

**DEVELOPMENT & BEHAVIOR**

Age at which child \_\_\_\_\_

Sat alone \_\_\_\_\_ Walked \_\_\_\_\_ Used sentences \_\_\_\_\_

Toilet trained \_\_\_\_\_ Bicycled \_\_\_\_\_

Development compared to other children? \_\_\_\_\_

Grade in school \_\_\_\_\_ Problems in school?  YES  NO

Learning problems?  YES  NO

Getting along with other children?  YES  NO

Behavior problems?  YES  NO

Bad habits?  YES  NO Bedwetting?  YES  NO

Nail biting?  YES  NO Sleeping?  YES  NO

Hobbies-sports- \_\_\_\_\_

Use of street or illegal drugs?  YES  NO

**SYNOPSIS**



**PURI PEDIATRIC  
Medical Group, Inc.**  
*Diplomate, American Board of Pediatrics*

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