

## PREFERRED PEDIATRICS PATIENT QUESTIONNAIRE

(Also see Pediatric Record)

FORM COMPLETED BY: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_ NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ LOCATION OF BIRTH (Hospital or City): \_\_\_\_\_

	NAME	YEAR OF BIRTH	HEALTH PROBLEMS	AT HOME?	OCCUPATION
<b>FAMILY HISTORY</b>	FATHER:				
	MOTHER:				
	SIBLINGS:				
<b>PATIENT'S BIRTH HISTORY AND DEVELOPMENT</b>	Birth Weight _____ <input type="checkbox"/> Full Term or <input type="checkbox"/> Premature <input type="checkbox"/> Vaginal Delivery or <input type="checkbox"/> C-Section                Baby's condition at birth and in the newborn nursery? <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal(explain) _____ Sat Alone _____ Mo. Walked Alone _____ Mo. First Words _____ Mo. Is your child's development normal as far as you know? <input type="checkbox"/> Yes <input type="checkbox"/> No COMMENTS:				
<b>PATIENT'S PAST MEDICAL HISTORY (REVIEW OF SYSTEMS)</b>	Has your child ever had any problems in the following areas? Please check all that apply: <input type="checkbox"/> Allergies/Eczema <input type="checkbox"/> Eyes (glasses?) <input type="checkbox"/> Ears, nose, mouth, throat <input type="checkbox"/> Recurrent ear infections <input type="checkbox"/> Hearing <input type="checkbox"/> Heart <input type="checkbox"/> Lung problems <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> GI (stomach, intestines) <input type="checkbox"/> GU (urine, bladder, kidneys) <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Psychiatric/Behavior/Emotional <input type="checkbox"/> School Problems <input type="checkbox"/> Hematologic/Immunologic/Infections <input type="checkbox"/> Anemia <input type="checkbox"/> Chickenpox <input type="checkbox"/> Meningitis (Brain Infection) <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Sepsis <input type="checkbox"/> Neurologic (Seizures, concussions, head injuries, etc.) COMMENTS:				
<b>PATIENT'S PRIOR HOSPITALIZATIONS, OPERATIONS, MAJOR ILLNESSES OR SERIOUS INJURIES</b>	_____ _____ _____ _____ _____ (Please describe and give dates)				
<b>FAMILY HISTORY</b>	Do parents, grandparents, or other children have any of the following? If so, check box. <input type="checkbox"/> Allergies/Eczema <input type="checkbox"/> Deafness <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity/Size <input type="checkbox"/> Anemia <input type="checkbox"/> Heart disease/Heart attacks <input type="checkbox"/> Psychiatric diseases <input type="checkbox"/> Alcoholism <input type="checkbox"/> High blood pressure <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Kidney disease <input type="checkbox"/> Seizures/convulsions <input type="checkbox"/> Blindness <input type="checkbox"/> Liver disease <input type="checkbox"/> Sickle Cell Disease/Trait <input type="checkbox"/> Cancer <input type="checkbox"/> Mental retardation <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Congenital anomalies <input type="checkbox"/> Tuberculosis COMMENTS:				
<b>ALLERGIES</b>	<input type="checkbox"/> None				
<b>CURRENT MEDICATION</b>	 				

**FOR THE STUDENT ATHLETE, PLEASE COMPLETE THE REVERSE SIDE OF PAGE**

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