PEDIATRIC & ADOLESCENT CARE

Health questionnaire for children 2 and over.

Dear Parent:

By filling out this questionnaire, you give us a more complete record of your child. It also provides a permanent history we can refer to later. It saves your time and ours. Answer any question you can. Don't worry about those you skip. We will discuss with you any items that either you or we believe should be explained more fully.

Full name of Child:_____and today's date_____

Date of Birth_____Place of Birth: Hospital_____City & State_____

Previous Pediatrician_____City & State_____

Do you have any specific concerns?_____

_____

A. Pregnancy and birth:

1. Did you have any illnesses or problems during your pregnancy? ..... No _____Yes _____
2. Were there any problems with your labor or delivery? ..... No _____Yes _____
   Type of Delivery: C-section_____ Vaginal _____
3. Did the baby come on time? ..... Yes _____No _____
4. What was the birth weight? _____
5. Did your baby have any trouble starting to breathe? ..... No _____Yes _____
6. Did he have any trouble during the hospital stay? ..... No _____Yes _____
   If yes, what type of problems_____

B. Feeding and digestion:

1. Are there any concerns about your child's appetite? ..... No _____Yes _____
2. Do any foods disagree with him? ..... No _____Yes _____
   if any, please state_____
3. Does he often have diarrhea? ..... No _____Yes _____
4. Does he often complain of his stomach hurting? ..... No _____Yes _____
5. Has constipation ever been much of a problem? ..... No _____Yes _____
6. Does he take vitamins? ..... Yes _____No _____
   State what vitamins_____
7. Does your water contain floride to prevent tooth decay? ..... Yes _____No _____

C. Infections, Illnesses, Miscellaneous complaints:

1. Has he had any trouble with his eyes? ..... No _____Yes _____
   Have his eyes been tested in the past year ..... Yes _____No _____
2. Has your child had as many as three spells of ear problems? ..... No _____Yes _____
3. Does he hear well? ..... Yes _____No _____
4. Does he have more than three throat infections a year? ..... No _____Yes _____
5. Do the glands in his neck often enlarge? ..... No _____Yes _____
6. Does he have any trouble with urination or kidneys? ..... No _____Yes _____
7. Has he ever had any trouble with his feet and legs? ..... No _____Yes _____
8. Does he ever complain of headaches? ..... No _____Yes _____
9. Underline any of the following that your child has had: "red measles," mumps, chicken pox, whooping cough, roseola, german measles, serious accidents, broken bones, mouth breathing, snoring, tiring easily, bad teeth, heart murmur, joint pain convulsions, pneumonia, other _____.
10. Has he ever had surgery? ..... No _____Yes _____
    If yes, type of surgery and age _____
11. Has he ever been hospitalized? ..... No _____Yes _____
    If so, for what? _____
12. Is your child on any chronic medications? ..... No _____Yes _____
    If yes, please name the medications_____

D. Allergies:

1. Has he ever had eczema or allergic rash? ..... No _____Yes _____
3. Does his cold usually go to his chest? ..... No _____Yes _____
4. Has he ever had wheezing or shortness of breath? ..... No _____Yes _____
5. Has he ever had any reaction to a drug or food? ..... No _____Yes _____
   If, yes what drug(s)?_____ What Food(s)_____

E. Environment:

Please list the names and relationship of those individuals who live in your house:_____

_____

Usual caretaker for child:_____

Are there smokers in the home? ..... No _____Yes _____
Is your child in daycare? ..... No _____Yes _____
Was your house built before 1960? ..... No _____Yes _____
Do any household members come in contact with toxic chemicals or lead? ..... No _____Yes _____
If yes please describe:_____

(Turn Over)

F. Development and general management:

1. Do you have any unusual problems in managing your child? ..... No _____ Yes _____
2. Is he doing well in school? ..... Yes _____ No _____
3. Do you have to give him many "spankings?" ..... No _____ Yes _____
4. Did he sit alone at or before 7 or 8 months of age? ..... Yes _____ No _____
5. Did he walk at or before 14 or 15 months of age? ..... Yes _____ No _____
6. Did he say any words by the time he was a year old? ..... Yes _____ No _____
7. Does he have any trouble sleeping now? ..... No _____ Yes _____
8. Have you ever had a sleep problem with him? ..... No _____ Yes _____
9. Underline any of the following problems your child has:
   Nail biting, thumb sucking, bed wetting, breath holding, lying, stealing, speech problems, disobedience, bad temper, irritability, nightmares, jealousy, toilet training difficulty.
10. Underline any of the following terms that apply to your child at the present time:
    Affectionate, aggressive, bullying, calm, cheerful, destructive, friendly, frightened, generous, nervous happy, helpful, jealous, kind, lonely, lying, obedient, pleasure for you, stealing, stubborn, worried.
11. How do you feel your child compares to other children the same age in regard to the following:
    Muscle coordination ..... Advanced _____ Average _____ Behind _____
    Language skills ..... Advanced _____ Average _____ Behind _____
    Learning abilities ..... Advanced _____ Average _____ Behind _____
13. List any other problems: _____

G. Family History:

1. Have any close relatives had problems with the following:

	Relationship to this child (parent, grandparent, sibling, aunt, uncle)
_____ Allergies	
_____ Anemia	
_____ Asthma	
_____ Bleeding Tendency	
_____ Cancer	
_____ Chronic Lung Disease or frequent infections	
_____ Deafness	
_____ Diabetes	
_____ Epilepsy	
_____ Eye Disorders	
_____ High Blood Pressure	
_____ Heart Trouble	
_____ Immunity weakness or disorder	
_____ Kidney Diseases	
_____ Liver Diseases	
_____ Thyroid Problems	
_____ Tuberculosis	

2. Is the child's mother living and in good health? ..... Yes ____ No ____
   Name _____ and age _____
3. Is the child's father living and in good health? ..... Yes ____ No ____
   Name _____ and age _____
4. List ages, sex, and general health of this child's brothers and sisters:
   Name _____ Age _____ Sex ___ Health OK ____ Not OK _____
   Illnesses: _____
   Name _____ Age _____ Sex ___ Health OK ____ Not OK _____
   Illnesses: _____
   Name _____ Age _____ Sex ___ Health OK ____ Not OK _____
   Illnesses: _____

H. Tests and Immunizations:

********* *Please attach a copy of your child's immunization record or fill in below:* ********

Immunization	Number	Date of Last One	Immunization	Number	Date of Last One
DTP or DtaP	_____	_____	Haemophilus (Hib)*	_____	_____
Polio	_____	_____	Hepatitis B	_____	_____
MMR	_____	_____	Chicken Pox	_____	_____
Pneumococcal	_____	_____	Influenza	_____	_____

1. Has he had a blood test? ..... Yes _____ No _____
2. Has he had a chest x-ray? ..... Yes _____ No _____
3. Has he had a urine test? ..... Yes _____ No _____

*Hib may have been combined with DTP

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