Pediatric & Adolescent Care

Health questionnaire for children under 2.

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. Were there any problems or illnesses 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. How do you feed your baby?.....Breast _____Bottle _____
   If breast, to what age? _____
   If formula, what type of formula_____
   Did you have to make any formula changes? ....No_____Yes_____
2. Did he have any feeding problems or colic the first three months?..... .....No_____Yes_____
3. Does your baby have problems with spitting up?..... .....No_____Yes_____
4. Are there any concerns about your child's appetite? ....No_____Yes_____
5. Do any foods disagree with him? ....No_____Yes_____
   if any, please state_____
6. Does he often have diarrhea?..... .....No_____Yes_____
7. Does he often complain of his stomach hurting?..... .....No_____Yes_____
8. Has constipation ever been much of a problem? ....No_____Yes_____
9. Does he take vitamins?..... .....Yes_____No_____
   State what vitamins_____
10. 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. Does he have any trouble with urination or kidneys?..... .....No_____Yes_____
6. Has he ever had any trouble with his feet and legs?..... .....No_____Yes_____
7. 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 _____.
8. Has he ever had surgery? ....No_____Yes_____
   Type of surgery and age _____
9. Has he ever been hospitalized?..... .....No_____Yes_____
   If so, for what? _____
10. Is your child on any chronic medications? ....No_____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_____
   What drug(s)?_____ What Food(s)_____

(turn over)

E. Environment:

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

_____

Usual caretaker for your 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:_____

F. Development and general management:

1. Do you have any unusual problems in managing your child?..... No_____Yes_____
2. Do you have to give him many "spankings?"..... No_____Yes_____
3. Did he sit alone at or before 7 or 8 months of age?..... Yes_____No_____
4. Did he walk at or before 14 or 15 months of age? ..... Yes_____No_____
5. Did he say any words by the time he was a year old? ... Yes_____No_____
6. Does he have any trouble sleeping now?..... No_____Yes_____
7. Underline any of the following terms that apply to your child at the present time:
   Affectionate, calm, cheerful, nervous, happy, active, busy, cries easily, easily consolable.
8. 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_____
9. 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