Pediatric Medical History Questionnaire

Name: _____

Date of Birth: _____

Person completing this form: _____

Please list all adults who are permitted to bring the child for care or receive medical information about the child:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Please list any **medical problems**, past or present, that your child has been treated for by a medical provider (examples: asthma, allergies, congenital malformations, diabetes)

_____

_____

_____

_____

Birth History:

List any pregnancy complications (pre-eclampsia, maternal diabetes, premature delivery):

_____

Was child delivered term (40weeks)? _____ If not, how many weeks old when born? _____

Birth Weight: ____ lbs ____ ounces

List any complications after child was born, up to about 2 weeks of age: _____

Please list any **surgeries** and approximate dates:

_____

_____

Please list any **hospitalizations** and the reason hospitalized, along with approximate dates:

_____

_____

Please list all of **current medications**, including dosage. Also include any over-the-counter medications or vitamins:

_____ _____

_____ _____

Immunizations: ☐ Up to Date ☐ Not Up to Date ☐ Not immunized ☐ Unsure

List the medical office (s) who have administered your child's vaccines:

_____

_____

Drug Allergies: _____

_____

Home/Social History:

Who lives in the home with your child?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Marital Status of parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married

Does anyone smoke around child? _____ If yes, who? _____

Are there any guns in the home? _____ If yes, are they locked up? _____

School: ☐ Public School ☐ Private School ☐ Home Schooled

If attends public or private school, please name school: _____

What grade level? _____

School performance: ☐ Above Average ☐ Average ☐ Below Average

Discipline problems? _____

List current sports that child is actively involved in: _____

Please list any food allergies or diet restrictions that your child is on:

_____

Do you feel that your child eats healthy? _____

If not, please list concerns: _____

Please list the number of hours per day your child spends doing the following activities:

Playing sports: _____ Doing Homework: _____ Sleeping: _____

Watching TV: _____ Playing Video Games: _____

Computer/Internet: _____

Family History: Please list illnesses, if known, pertaining to relatives listed below.

** If child is adopted or family's medical history is unknown, please check here: _____

Mother: ☐Alive ☐Deceased List current age, or the age she died: _____

Medical problems, if any:

_____

Father: ☐Alive ☐Deceased List current age, or the age he died: _____

Medical problems, if any:

_____

Brothers:

How many? _____ List current ages if applicable: _____

Medical problems, if any: _____

Sisters:

How many? _____ List current ages if applicable: _____

Medical problems, if any:

_____

List any major medical problems that grandparents or aunts/uncles have, especially anything pertaining to heart disease, diabetes, stroke, or cancers:

_____

_____