MRN ________________________________ CSN ______________________________

PEDIATRIC HISTORY QUESTIONNAIRE

Birth to 4 years old

Child's Full Name (Last, First, M.I.): ❑ M ❑ F		**Age:**
Birthdate:	**Place Child was Born:**	
Previous doctor:	**Last time child was at the doctor's:**	

HEALTH HISTORY			
Any Problems in Pregnancy: ❑ No ❑ Yes	If yes, what was wrong? ❑ Illness ❑ Bleeding ❑ Infection ❑ Other:		
Any Problems with Delivery? ❑No ❑ Yes	If yes, what was wrong? ❑Premature ❑C-Section ❑Breech ❑Forceps/Vaccuum ❑Other:		
Birth weight?	**Length?**	**Breastfed?** □ No □ Yes	**Bottlefed?** □ No □ Yes
Did the child have any problems after birth? ❑No ❑Yes	If yes, what was wrong? ❑Feeding ❑Weight loss ❑Jaundice ❑Fever ❑Other:		
Was the child ever in NICU: ❑No ❑Yes	**Did the child go home with mom on the same day:** ❑No ❑Yes		
What age did your child first:	Roll over:	Sat up alone:	Stood alone:
	Walked alone:	Said first word:	Babble:
	Using 2 words together:	Use Sippy cup:	Used the toilet:

Has your child had shots? ❑ No ❑ Yes ❑ I don't know
Where were the shots given?
Do you know if the child is up to date on shots? ❑ No ❑ Yes ❑ I don't know

Is your child allergic to anything (medicine, foods, pollens, etc): ❑ No ❑ Yes
If yes, what is it and what happens?

List the times when your child was in the hospital, had surgery or any serious injuries:		
Month/Year	Reason	Hospital

Has your child had any of the following problems:					
❑ Chicken pox	❑ Measles	❑ Mumps	❑ Scarlet fever	❑ Rheumatic Fever	❑ Rubella (German measles)
❑ Chronic ear infections	❑ Asthma	❑ Eczema	❑ Lead Poisoning	❑ Burns	❑ Heart Murmur
❑ Diabetes	❑ Dehydration	❑ Reflux	❑ Anemia	❑ Seizure	❑ Urinary Tract Infection

Signature of person filling out his form ________________________________ Date ___________ Relationship to Child ______________________

MRN ________________________________ CSN ______________________________

List all medicines your child is taking (including prescribed drugs and over-the-counter drugs, such as vitamins, inhalers, cough medicines, Tylenol, ibuprofen, etc)			
Name the Drug	How often it is given	Name the drug	How often it is given
1.		2.	
3.		4.	
5.		6.	

What medical problems are in the child's family? (both mother's and father's side, also siblings)	

SOCIAL HISTORY

Who does the child live with?	❑ Both Parents				
	❑ One parent who? ❑ Mother ❑ Father				
	❑ Step Parent				
	❑ Relatives who?:				
	❑ Foster Parent				
Family Stressors	❑ Marriage problems	❑ Money problems	❑ Legal problems	❑ Discipline problems	
	❑ Insurance problems	❑ Alcohol	❑ Drugs	❑ Abuse	
School	**Does your child go to school or daycare?** ❑ Yes ❑ No				
	If yes, what is the name of the School?	Any problems in school/daycare? ❑ Yes ❑ No			
	What level in school/daycare is the child?				
Does your child have problems with any of these?	❑ Bedwetting	❑ Thumb sucking	❑ Nail biting	❑ Breath holding	❑ Temper tantrums
	❑ Sleeping	❑ Eating	❑ Habits	❑ Fear	❑ Not speaking
	❑ Weird movements	❑ Does not play with others	❑ Biting	❑ Hitting	❑ Potty training
Home	Are there any smokers in the home? ❑ Yes ❑ No				
	What pets are in the home?				
	Does your child have a car seat? ❑ Yes ❑ No				
	If yes, do you use it every time the child is in the car? ❑ Yes ❑ No				

OTHER PROBLEMS

Check if your child has had problems have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

❑ Skin	❑ Eyes	❑ Ears	❑ Nose	❑ Throat	❑ Teeth	❑ Lungs	❑ Heart	❑ Stomach/Intestines
❑ Kidneys	❑ Bladder	❑ Bones	❑ Muscles	❑ Joints	❑ Blood	❑ Brain		

List any additional information you feel would be helpful for your doctor to know

Signature of person filling out his form ________________________________ Date __________ Relationship to Child ______________________