HEALTHY KIDS PEDIATRICS

Patient History Questionnaire

Patient Name _____ Date of Birth _____

Parent Name _____ Phone #_____ Current Date _____

Welcome to our office. This questionnaire has been designed so that we can both review your child's medical history and factors in her/his life that affect health. It is long and detailed! Some questions may not apply, depending on the age of your child; you may skip these. All information collected will be kept strictly confidential. Thank you for your patience.

General Health: ❒ excellent ❒ good ❒ fair ❒ poor

Past Medical Illnesses:

(Please list any illnesses that have required hospitalization and any other significant health problems)

❒ problems during pregnancy, birth, or in the newborn period
Birth weight: _____
❒ C-Section ❒ Vaginal Birth
❒ Breast fed How long: _____
❒ Formula fed Which brand: _____
❒ accidents, broken bones, other serious injury
❒ allergies(asthma,eczema,hay fever), food allergies
❒ anemia (low blood count) or bleeding problems
❒ bladder/kidney problems: frequent infections, control problems (if unusual for child's age)
❒ growth problems: poor weight gain, etc.
❒ emotional problems: depression, ongoing or past abuse concerns, behavior problems
❒ heart problems, murmur, etc.
❒ gastrointestinal problems: frequent upset stomach, diarrhea
❒ lung problems: pneumonia, asthma, etc
❒ neurologic: seizures, developmental or learning disabilities, cerebral palsy, headaches
❒ skin problems
❒ sleep problems: insomnia, night terrors, etc.
❒ tuberculosis (or positive skin test)

Details of any of the above checked or any specific diagnoisis that has been given to patient:

_____

_____

_____

_____

Are his/her immunizations up to date? ❒ yes ❒ no When was his/her last dental visit?_____

Please bring immunization record to first appointment.

Past Surgery (include approximate date and type of procedure):

_____

_____

_____

_____

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Current medications (include over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, etc. and indicate dose and frequency):

_____

_____

_____

Allergies to any Medication: (list medication and reaction): _____

_____

Family History:

Is your child adopted or from a donor insemination? . . . . . ❒ yes ❒ no

Please list medical history for biological relatives:

Relationship	Name	Age	Living/Deceased	Medical Problems
Mother	_____	___	_____	_____
Father	_____	___	_____	_____
Brothers/Sisters	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____

Is there any history in the family of the following illnesses?

(Include mother(M), father(F), sister(S), brother(B), paternal grandmother (PG), paternal grandfather(PG), maternal grandmother (MG), maternal grandfather (MG) aunts(A), uncles(U), cousins(C).)

	YES	NO	UNSURE	WHO?
Alcoholism or drug abuse	❒	❒	❒	_____
Allergies, severe	❒	❒	❒	_____
Attention deficit/learning disorders	❒	❒	❒	_____
Bleeding problems	❒	❒	❒	_____
Blood clots in legs or chest	❒	❒	❒	_____
Depression or mental illness	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
				(What organ(s)?)
Heart problems, before age 50	❒	❒	❒	_____
Kidney disease	❒	❒	❒	_____
Liver disease	❒	❒	❒	_____
Lung disease	❒	❒	❒	_____
Mental retardation	❒	❒	❒	_____
Tuberculosis	❒	❒	❒	_____
Other:	❒	❒	❒	_____

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Social History:

Please list everyone who lives in the home with this child and note relationship:

Full Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Brothers/sisters and parents not living in the home:

Full Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child get along well with her/his siblings? . . . . . ❒ yes ❒ no
Are you currently providing care for a disabled or elderly family member? . . . . . ❒ yes ❒ no

School history

Is your child currently in school?. . . . . ❒ yes ❒ no

❒ Home school ❒ Public school ❒ Private school

What grade level? _____

Has she or he had any difficulty in school and, if so, what was the problem?

_____

_____

What action was taken?

_____

_____

Does your child play well with other children?. . . . . ❒ yes ❒ no

How many hours of television/videos does your child watch every day? _____

Discipline

What is your method of discipline? _____

Is discipline a problem for you? _____

How do adults in the home deal with conflict? _____

Abuse

Has your child ever experienced physical or sexual abuse?. . . . . ❒ yes ❒ no

Did she or he receive any counseling? . . . . . ❒ yes ❒ no

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Travel: Has your child ever been in (or is he/she from): ❒ a foreign country?

❒ another region of the United States?

Diet: Does your child follow a special diet? (vegetarian, low salt, low fat etc) . ❒ no ❒ yes: _____

How many times a week does your family eat red meat? _____

How many servings of fruit or vegetables does your child eat every day? _____

What do you give your child for snacks? _____

How many sodas (Coke, Pepsi, etc.) does your child drink every day? _____

How many servings of chips, candy does your child eat every day? _____

Has weight ever been a problem for your child?. . . . . ❒ yes ❒ no

Are you concerned about your child undereating or being preoccupied with weight? . . . . . ❒ yes ❒ no

Has weight ever been a problem for the parents or other adults in the home?. . . . . ❒ yes ❒ no

Has your child ever had to limit certain foods because of a bad reaction to those foods?. . . . . ❒ yes ❒ no

Which foods, what reaction, and do they still avoid those foods:

_____

_____

Timeline: Please provide a detailed timeline from birth until now: (including any diagnosis, when and where of diagnosis/any treatments or medications.)

_____

_____

_____

_____

_____

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_____

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_____

HEALTHY KIDS PEDIATRICS

Please list what your child eats weekly, with approximate amounts. (Top 5 foods) If you are breast feeding, please use your diet:

Breakfast	Lunch	Supper	Snacks/Drinks

Diet: Does your child follow a special diet? (vegetarian, low salt, low fat etc) . ❒ no ❒ yes: _____

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Has your child ever had to limit certain foods because of a bad reaction to those foods?. . . . . ❒ yes ❒ no

Which foods, what reaction, and do they still avoid those foods:

_____

_____

Exercise: Does your child exercise daily? . . . . . ❒ yes ❒ no

What kind of exercise/play does he/she enjoy? _____

Does she/he have safety equipment for bicycles, roller skates, etc.? . . . . . ❒ yes ❒ no

Hobbies, other activities(church groups, sports, musical instruments, etc.):

_____

_____

_____

HEALTHY KIDS PEDIATRICS

Other providers involved in your child's care:

Do you see other health care providers for your child (such as a therapist, other physicians, chiropractors, acupuncturists, herbalists, etc.) on a regular basis? . . . . . ❒ yes ❒ no

Name _____ Profession _____

Would you like your medical provider at the clinic to consult with or coordinate your child's care with her/his other provider(s)? . . . . . ❒ yes ❒ no

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Current symptoms:

Check symptoms or problems your child has now or occasionally, and write details below:

Allergies: ❒ sinus congestion, ❒ skin rashes, ❒ asthma

Nervous system problems: ❒ fainting, ❒ dizziness, ❒ blurry/double vision, ❒ hearing problems

Stomach problems: ❒ indigestion, ❒ abdominal pain, ❒ diarrhea, ❒ constipation, ❒ blood in stools

Lung problems: ❒ cough, ❒ shortness of breath, ❒ wheezing, ❒ hoarseness

Heart problems: ❒ chest pain, ❒ palpitations, ❒ trouble breathing lying flat, ❒ fainting spells

Circulatory problems: ❒ leg swelling, ❒ leg cramps with exercise or at night

Skin: ❒ rash, ❒ changing mole(s), ❒ itching, ❒ warts

❒ Growth problems

❒ Joint problems, ❒ back pain

Bladder/kidney problems: ❒ frequent urinary tract infections, ❒ loss of control of urine(accidents) (inappropriate for age), ❒ problems with foreskin or circumcision.

Problems with sexual development: ❒ breast development, ❒ hair growth, ❒ periods starting before expected

Sleep problems: ❒ insomnia, ❒ daytime sleepiness, ❒ snoring,

❒ Behavior problems, ❒ learning problems, ❒ development problems,

Development: At what age did your child sit?_____

At what age did your child walk? _____

At what age did your child talk? _____

Does your child wear glasses? ❒ yes ❒ no Contact lenses? ❒ yes ❒ no Braces? ❒ yes ❒ no

HEALTHY KIDS PEDIATRICS
Please provide IN GREAT DETAILS the problems checked above.

Please summarize your concerns about your child's health and prioritze what you would like Healthy Kids Pediatrics to help you with.