

mmpc pediatrics

HEALTH QUESTIONNAIRE AGES BIRTH TO 12 YEARS

Patient Name _____ Birth date ___/___/___
 Male Female

Person Completing History _____ Today's Date ___/___/___

FAMILY PROFILE:

Child's mother: Name _____
Age _____ Birth date ___/___/___
Employment _____
Health status _____

Child's father: Name _____
Age _____ Birth date ___/___/___
Employment _____
Health status _____

Child's brothers and sisters

| Name | Sex | Age | General Health |
|------|-----|-----|----------------|
|------|-----|-----|----------------|

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Members living in the household:

Is your child currently in daycare Yes No
If yes, what kind (center, private in home, etc)

PRENATAL HISTORY:

Which pregnancy was this for you (1st, 2nd, etc)? _____

Have you ever miscarried? Yes No

Have any of your children died? Yes No If yes, what was the cause? _____

Did you receive prenatal care during this pregnancy? Yes No

Did you have any medical problems during this pregnancy? Yes No

If yes, please list _____

During this pregnancy did you:

Smoke? Yes No

Use Alcohol? Yes No

Use Medications? Yes No

Take illegal Drugs? Yes No

Have any infections? Yes No

BIRTH HISTORY:

Hospital where your child was born: _____

How many months pregnant were you when this child was born? _____

Were there any problems with labor or delivery? Yes No

If yes, please, list _____

Type of delivery (check one) Vaginal Vaginal with forceps C-section

Baby's birth weight _____

After birth, did the baby have (check all that apply):

Jaundice Heart murmur Infection Breathing Problems Birth Defect

Other problems _____

FAMILY HISTORY:

Please circle any of the following diseases that any of the child's parents, grandparents, aunts, uncles, brothers or sisters have had:

| | | | |
|--------------------|------------------|---------------------------|--------------------|
| Alcoholism | Cancer | Heart disease (childhood) | Mental Retardation |
| Allergies | Cystic Fibrosis | Heart disease (adulthood) | Seizures |
| Asthma | High Cholesterol | Sickle Cell Disease | |
| Deafness | Diabetes | Kidney Disease | Tuberculosis |
| Bleeding disorders | Drug abuse | Mental Illness | |
| Blindness | | | |

Does anyone in the household smoke? Yes No

FEEDING HISTORY:

Type of feeding (check all that apply): Breast Formula Kind of formula _____

Were there any feeding problems in the first 3 months? Yes No
Is your child's appetite usually good? Yes No
Do you feel like your child eats a balanced diet? Yes No
Does your child take vitamins? Yes No
Do you have fluoride in your drinking water? Yes No
Does your child have any problem with constipation? Yes No
Does your child have any food allergies? Yes No

DEVELOPMENTAL and MEDICAL HISTORY:

At what age did your child:

Sit alone _____ Walk alone _____ Say his/her first word _____

Does your child appear to have any trouble hearing? Yes No
Does your child appear to have any trouble seeing? Yes No
Does your child have any difficulty sleeping? Yes No
Does your child have any problems with his/her teeth? Yes No
Does your child visit a dentist regularly? Yes No
Has your child had 3 or more ear infections? Yes No
Does your child have trouble going to the bathroom? Yes No
Has your child ever had a convulsion or seizure? Yes No
Has your child ever had hives or eczema? Yes No
Has your child ever had any wheezing or asthma? Yes No
Has your child ever had any allergies or reactions to medications? Yes No

Please check which of the following your child has had:

Chickenpox Measles Pneumonia

Are your child's immunizations up to date? Yes No

Please date and describe all the following that apply to your child:

Broken bones _____
Serious Accidents _____
Operations _____
Hospitalizations _____

Do you have any concerns about your child not already listed? _____

