



PEDIATRIC QUESTIONNAIRE/HISTORY FORM

PEDIATRICIAN: _____

Height: _____ Weight: _____

Why is your child being seen? _____

PRENATAL DEVELOPMENT:

Pregnancy: No complications: Complications: _____

Delivery: Gestational Age: _____ Vaginal _____ C Section (please explain reason) _____

CHILD'S PAST MEDICAL HISTORY: (circle all that apply)

- | | | | |
|---------------------|------------------------|--------------|----------------|
| Diabetes | Heart Problems | Diarrhea | Cancer |
| High Blood Pressure | Developmental Concerns | Constipation | Lung Problems |
| Kidney Disease | Anemia | Immunization | Social Problem |

OPERATIONS:

- | | | | |
|--------------|------------------|----------|-----------------|
| Circumcision | Testicle Surgery | Hernia | Bladder Surgery |
| Tonsils | Kidney Surgery | Appendix | Heart Surgery |

HOSPITALIZATIONS: List all previous hospitalizations with dates of treatment

MEDICATIONS: Please include dosage and times

MEDICATION ALLERGIES: _____

FAMILY HISTORY: (Circle all that apply)

Kidney Disease
Diabetes
Cancer
Diarrhea

Anesthesia Problems
Heart Disease
High Blood Pressure
Bedwetting

Bleeding Problems
Urinary Tract Infections
Kidney Reflux
Stroke

Constipation
Kidney Stones

REVIEW OF SYSTEMS: (please check all rows)

	Yes	No
1. Constitutional Symptoms:		
Fever		
Chills		
Headaches		
2. Eyes		
Poor Vision		
3. Head and Neck		
Hearing Loss		
Sore Throat		
4. Cardio Vascular		
High Blood Pressure		
Heart Murmur		
5. Respiratory		
Cough		
Asthma		
6. GastroIntestinal		
Constipation		
Diarrhea		
7. Musculoskeletal		
Broken bone		

	Yes	No
8. Hematologic		
Easy bruising		
Bleeding Disorder		
9. Allergic		
Allergies		
Hay Fever		
10. Neurologic		
Seizures		
Muscle Weakness		
11. Genital		
Hernia		
Testicle Problems		
Hypospadias		
12. Developmental		
ADHD		
Depression		
Anxiety		
13. Age Potty Trained		
14. Age Menses Began		

SOCIAL:

Grade in School: _____

Living with	Mom	<input type="checkbox"/>
	Dad	<input type="checkbox"/>
	Both	<input type="checkbox"/>

Cigarette Use
Alcohol Use

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>