Pediatric Health History Questionnaire:

Child's name_____ Date of birth_____

Mother's name: _____ Father's name:_____

Address_____

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
☐ Fever or rash	☐ Tobacco use (how much)
☐ Group B strep	☐ Alcohol use (how much)
☐ Sugar in urine / diabetes	☐ Street drug use (what type)
☐ High blood pressure	☐ Medication use (prescription or over-the-counter - list below)
☐ Anemia	
☐ Infections (if yes what type and how were they treated)	

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early ☐ Late	How much:	
Type of delivery ☐ Vaginal ☐ C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following		
☐ Feeding trouble	☐ Seizures	☐ Fever
☐ Excess vomiting	☐ Breathing trouble	☐ Receive antibiotics
☐ Jaundice (yellow skin)	☐ Need of oxygen	☐ Diarrhea
☐ Cyanosis (blueness)	☐ Blood transfusion	☐ In intensive care unit

Family History				
Relationship	Name	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father				
Mother				
Siblings				
If more than 3 siblings continue on back				

Specifically have any of the child's relatives had the following conditions

Condition	Relative	Condition	Relative
☐ Diabetes		☐ Kidney problems	
☐ Cancer		☐ Heart disease	
☐ Seizures		☐ Stroke	
☐ Allergies/asthma		☐ Anemia	
☐ Bleeding problems		☐ HIV	
☐ High blood pressure		☐ Skin problems	
☐ Lung disease		☐ Chemical dependency	
☐ Mental illness		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

Past Medical History
Where has child gone for check-ups previously:

Date of last medical checkup:
Date of last dental check-up:
Is your child up-to-date on immunizations? Please supply immunization records.

Has your child had any of the following		
☐ Chicken pox	☐ Wears glasses	☐ Asthma
☐ Measles	☐ Heart murmur	☐ Allergies
☐ Mumps	☐ Kidney or bladder infection	☐ Broken bones
☐ Frequent ear infections (>4 year)	☐ Bed wetting (>5 years old)	☐ Head injury
☐ Frequent throat infections (>4 year)	☐ Diabetes	☐ Seizures

Has your child ever been hospitalized or had surgery? If yes, list age and reason:
Has your child ever been on medication regularly that is not on their current medication list? If yes, list medication(s) and reason:
Do you have any concerns about your child's development? If yes, please describe:

Childs Social Characteristics	
School Grade/Preschool:	City Water: Yes / No
Hours of TV/Electronics Each Day:	Exposure to Second Hand Smoke: Yes / No
Special Diet:	Guns in Home: Yes / No
Weekly Hours of Outdoor Activity:	Wears Sunscreen: Yes / No
Pets:	Wears Seatbelt/Car Seat/Booster: Yes / No
Sports:	
Hobbies:	

Allergies	
Please list any allergies to medications or foods and environmental allergies	

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency (if more room is needed continue on back)	

It is very important that your child take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your child's prescription(s) because of the cost ☐ **Yes** ☐ **No**

Are you unable to fill your child's prescriptions because of lack of transportation ☐ **Yes** ☐ **No**

Have you ever applied for any pharmacy assistance ☐ **Yes** ☐ **No**

Specialty Providers

In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them (if more room is needed continue on back)

Health Literacy Questionnaire	
Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	**1 2 3 4 5 6 7 8 9 10**
I feel that I remember the instructions given to me at my doctor's office when I get home	**1 2 3 4 5 6 7 8 9 10**
I feel that I have a strong understanding of medical language	**1 2 3 4 5 6 7 8 9 10**

Parent Signature:_____ Date:_____

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