Bull City Family Medicine and Pediatrics

Date: _____

Pediatric Health History Questionnaire

Child's name _____ Date of birth _____

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

Siblings names and ages: _____

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)	

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

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?

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

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? If yes, list medication(s) and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Allergies	
Please list any allergies to medications or foods	

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency	

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

Parent Signature: _____ Date: _____