

Bull City Family Medicine and Pediatrics

Pediatric Health History Questionnaire

Date: _____

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?	
<input type="checkbox"/> Fever or rash	<input type="checkbox"/> Tobacco use (how much)
<input type="checkbox"/> Group B strep	<input type="checkbox"/> Alcohol use (how much)
<input type="checkbox"/> Sugar in urine / diabetes	<input type="checkbox"/> Street drug use (what type)
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Medication use (prescription or over-the-counter - list below)
<input type="checkbox"/> Anemia	
<input type="checkbox"/> 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
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney problems	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Seizures		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Allergies/asthma		<input type="checkbox"/> Anemia	
<input type="checkbox"/> Bleeding problems		<input type="checkbox"/> HIV	
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Skin problems	
<input type="checkbox"/> Lung disease		<input type="checkbox"/> Chemical dependency	
<input type="checkbox"/> Mental illness		<input type="checkbox"/> 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? <input type="checkbox"/> Early <input type="checkbox"/> Late	How much:	
Type of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> 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		
<input type="checkbox"/> Feeding trouble	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fever
<input type="checkbox"/> Excess vomiting	<input type="checkbox"/> Breathing trouble	<input type="checkbox"/> Receive antibiotics
<input type="checkbox"/> Jaundice (yellow skin)	<input type="checkbox"/> Need of oxygen	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Cyanosis (blueness)	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> In intensive care unit

