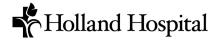


Pediatric Patient Questionnaire

Patient:		Date of Birth.:	
Pregnancy and Birth			
Mother's age at pregnancy Any illness during	pregnancy?		
Medications during pregnancy?	· · - ·		
Did you smoke, drink alcohol, or use illegal street drugs d			
Weeks of gestation: Place of birth:			
Type of delivery: Birth w			inches
Were there any complications during delivery?			
Problems with infant at birth?			
Were there any breathing problems at birth?			undice at birth? Yes No
Other problems?			
Were there any problems in the nursery or at home?			
Past Medical History			
List allergies:			
Medications taken on a regular basis:			
Immunizations up to date? Yes No Do you have			
Hospitalizations: when, where, why:	Serious Injui	ries: when, where	
1	1		
2			
3			
Has your child had any of the following (please check tho			
Red Measles Anemia	Ear Infections	German Measles	Vision Problems
Chicken Pox Bleeding tendency	Eczema	Rheumatic Fever	Joint Problems
Scarlet Fever Blood transfusions	Hives	Strep Throat	Mumps
Asthma Mumps	Hepatitis	Seizures	
Wheezing Whooping Cough	Urinary Infections	Hearing Problems	
Other:			
Feeding and Nutrition			
Any know food allergies?			
Appetite usually good? Yes No			
Colic or feeding problems during the first three months o	fage? Yes No		
Breast fed? Yes No Number of months:	_	No Current brand:	
Vitamins? Yes No Brand		No Explain:	



Does your child use street or illegal drugs?

Anything else that you would like us to know about your child:

Family Profile Married Separated Divorced Parents: Father's Age: _____ Highest Level of Education: _____ Father's Health: _____ Mother's Age: _____ Highest Level of Education: _____ Mother's Health: ___ Sibling 2 Sibling 4 Siblings: Siblina 1 Sibling 3 Name Age Additional Siblings: Family Medical History List all blood relatives of your child who have had the following problems. Use abbreviations (F) father (M) mother (B) brother (S) sister (MM) mother's mother (MF) mother's father (FM) father's mother (FF) father's father (A) aunt(U) uncle (C) cousin Anemia / Blood Disorders: Asthma: Mental Retardation: Drug Problem: Alcoholism: Cancer: Aids: Cystic Fibrosis: Muscular Dystrophy: Tuberculosis: Arthritis: Epilepsy / Seizures: Heart Disease: High Blood Pressure: Cholesterol Problem: Migraines: Sudden Infant Death: Birth Defects: Early Deafness: Diabetes: Development and Behavior Please indicate the age at which your child: Sat Alone: _____ Walked: ____ Used Sentences: ____ Toilet Trained: ____ Bicycled: ____ Your child's development compared to other children: Your child's current grade in school: ___ Does your child have problems in school? Yes No Explain: Does your child have learning problems? Yes No Explain: Does your child get along with other children? Yes No Explain: Does your child have behavior problems? Yes No Explain: Does your child have any bad habits? Explain: Yes No Does your child wet the bed? Yes No Explain: Does your child bite his/her nails? Explain: Yes No Does your child have trouble sleeping? Yes No Explain: Does your child have any hobbies / play sports? Yes No Explain:

Explain:

Yes

No