Holland Hospital
PHYSICIAN OFFICES

Pediatric Patient Questionnaire

Patient Name:	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 during your pregnancy?	
Weeks of gestation:	Place of birth:
Type of delivery:	
Birth weight: lbs oz	Length: inches
Were there any complications during delivery?	
Problems with infant at birth?	
Were there any breathing problems at birth?	
Jaundice at birth?	
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? Do you have record?

Hospitalizations: when, where, why:

1.
2.
3.

Serious Injuries: when, where

1.
2.
3.

Has your child had any of the following:

Red Measles	Y	N	Mumps	Y	N	Rheumatic Fever	Y	N
Chicken Pox	Y	N	Whooping Cough	Y	N	Strep Throat	Y	N
Scarlet Fever	Y	N	Ear Infections	Y	N	Seizures	Y	N
Asthma	Y	N	Eczema	Y	N	Hearing Problems	Y	N
Wheezing	Y	N	Hives	Y	N	Vision Problems	Y	N
Anemia	Y	N	Hepatitis	Y	N	Joint Problems	Y	N
Bleeding tendency	Y	N	Urinary Infections	Y	N	Mumps	Y	N
Blood transfusions	Y	N	German Measles	Y	N			

Other:

Feeding and Nutrition

Any known food allergies?		
Appetite usually good?	Y	N
Colic or feeding problems during the first three months of age?	Y	N

Breast Fed	Y	N	Number of months:	Formula	Y	N	Current Brand:
Vitamins	Y	N	Brand:	Flouride	Y	N	
Special Diet	Y	N	Explain:				

Turn Over to Complete

Family Profile							
Parents:		Married		Separated		Divorced	
Father's Age:				Highest Level of Education:			
Father's Health:							
Mother's Age:				Highest Level of Education:			
Mother's Health:							
	Sibling 1		**Sibling 2**		**Sibling 3**		**Sibling 4**
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?	Y	N	Explain:
Does your child have learning problems?	Y	N	Explain:
Does your child get along with other children?	Y	N	Explain:
Does your child have behavior problems?	Y	N	Explain:
Does your child have any bad habits?	Y	N	Explain:
Does your child wet the bed?	Y	N	Explain:
Does your child bit his/her nails?	Y	N	Explain:
Does your child have trouble sleeping?	Y	N	Explain:
Does your child have any hobbies / play sports?	Y	N	Explain:
Does your child use street or illegal drugs?	Y	N	Explain:

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