PEDIATRIC QUESTIONNAIRE

Patient Name: _____ **Date of Birth:**_____

Name of Primary Care Provider: _____

DIAGNOSIS

Please describe your child's main medical diagnoses or problem(s) that you would like addressed today:_____

_____

_____

What factors or events, if any, do you believe may have triggered your child's problem/illness?_____

_____

_____

What are your goals of treatment for your child?_____

_____

_____

CURRENT SYMPTOMS AND HEALTH CONCERNS: circle all that apply

*Abdominal Pain	*Allergies	*Attention Problems
*Behavioral Difficulties	*Constipation	*Developmental Delay
*Diarrhea	*Eczema	*Energy Problems
*Environmental Issues	*Frequent Infections	*Medications/Therapies
*Nutrition	*Obsessions/Compulsions	*Seizures
*Sensory Issues	*Sleep Issues	*Tics

*Other Neurologic Issues (please describe):_____

* Other (please describe):_____

Please circle those that apply:

Alaska Native	African American	Hispanic	Mediterranean
Native American	Caucasian	Other: _____	

Please list any hospitalizations, emergency room visits, or surgeries:

1._____ 4._____

2._____ 5._____

3._____ 6._____

PAST MEDICAL HISTORY

*Abdominal Pain	*Allergies	*Attention Problems
*Behavioral Difficulties	*Constipation	*Developmental Delay
*Diarrhea	*Eczema	*Energy Problems
*Environmental Issues	*Frequent Infections	*Medications/Therapies
*Nutrition	* Obsessions/Compulsions	* Seizures
*Sleep Issues	*Tics	* Vaccinations

*Other (please describe):_____

Please list any medications or supplements that your child has taken in the past, including antibiotics and steroids:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc.
Supplement/Medication Dose Frequency How long?

_____
_____
_____
_____
_____
_____

BIRTH HISOTRY

PRENATAL/PREGNANCY HISTORY:
Illnesses during pregnancy: _____
_____
_____
Medications during pregnancy (rhogam, antibiotics, vaccines, herbs, supplements):_____
_____
_____

DELIVERY HISTORY

Mode of delivery: Vaginal delivery C-section Gestation: Preterm Full Term

Birth Weight: _____ Maternal Group B strep: Positive Negative

Complications:_____
_____
_____

POSTPARTUM HISTORY

Please describe any postpartum complications:_____

Did you or your child receive any medications after delivery? Yes No If yes, please explain:_____
_____

Did you suffer from postpartum blues/depression? Yes No

DEVELOPMENTAL HISTORY

Has your child's development been normal? Yes No

If no, please describe the development problems and at what age the problems began to appear. _____

_____

_____

ALLERGIES/SENSITIVITES

Please list any medications or supplements your child has had a reaction to. Describe the reaction.

_____

_____

_____

_____

ENVIRONMENTAL HISTORY

Does your home have a lot of: Dust Mold

Is your child exposed to cigarette smoke? Yes No

Please list any other exposures your child may have had in the past and present:

_____

_____

DIGESTIVE HISTORY

How often does your child have a bowel movement? _____

What is your child's stool like? (check all that apply)

Well-formed Mucousy Loose, falls apart Watery Small, hard Greasy/floats
Thin, long ribbons Bloody Foul-smelling Painful Lots of undigested food particles

Does your child have heartburn or reflux? Yes No

Does your child have frequent gas or belly bloating? Yes No

Does your child have any abdominal pain? Yes No

DIET HISTORY

Was your child breast fed? Yes No If yes, for how long? _____

Was your child bottle-fed? Yes No Brand of formula: _____

Do you have any concerns about your child's current diet? Yes No

Does your child eat refined sugar? Yes No Does your child eat fast food? Yes No

Please describe your child's current diet:_____

_____

Please describe your child's typical breakfast:_____

_____

Please describe your child's typical lunch:_____

_____

Please describe your child's typical dinner:_____

_____

Please describe your child's typical snacks:_____

_____

What does your child drink throughout the day?_____

SCHOOL HISTORY

School Name:_____ **Grade:** _____

Does your child have an Individualized Education Plan (IEP)? Yes No

Do you have any concerns regarding your child's school progress (academic, social, teacher, peer relationships)?
Yes No If yes, please explain: _____

_____

SOCIAL HISTORY

List the family and household members:
Relationship: Age: Occupation:

_____

_____

_____

_____

_____

_____

Are your child's parents: Married Unmarried Separated Divorced: When? _____

Child care situation: Parents Others:_____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? Yes No Are there guns in the home? Yes No

Are there pets in the home? Yes No Do any family members smoke? Yes No

Please describe any recent stressful events: _____

_____

_____

How does your child interact with other children?_____

_____

_____

How does your child interact with adults?_____

_____

_____

FAMILY MEDICAL HISTORY

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcoholism								
Anemia								
Asthma								
Autism								
Autoimmune Disorder								
Birth Defect/Congenital Anomaly								
Bleeding Problem								
Cancer: Breast								
Cancer: Type_____								
Cancer: Type_____								
Depression								
Developmental Delay								
Diabetes								
Eczema (Atopic Dermatitis)								
Food Allergy								
Genetic Disorder								
Hay Fever (Allergic Rhinitis)								
Hearing Disorder								
Heart Attack/Coronary Artery Disease								
High Cholesterol (Hyperlipidemia)								
High Blood Pressure								
Immune Disorder								
Inflammatory Bowel Disorder (Crohns/UC)								
Kidney Disease								
Migraine Headaches								
Psychiatric/Mental Illness								
Scoliosis								
Stroke								
Substance Abuse								
Thyroid Disorders								
Tobacco Use								
Tuberculosis								
Death before age 56								
Other:								