DELAWARE VALLEY PEDIATRIC ASSOCIATES PATIENT HISTORY QUESTIONAIRE

PATIENTS NAME:_____**DOB:**_____

PARENT INFO:

Parent's Name:_____ Age:_____
Occupation:_____
Parent's Name:_____ Age:_____
Occupation:_____
If parents work outside of the home, what are the childcare arrangements?
_____
Is the child in nursery school or preschool? { } Y { }N

PREGNANCY & BIRTH

Mother's age at birth: _____
Did mother have any illness during pregnancy? { }Y { }N
If so, what?_____
Did mother take medications other than vitamins?{ }Y { }N
If so, what?_____
Was baby premature? { }Y { }N If so how many weeks? _____
Birth Weight:_____lbs _____oz Legnth:_____ APGAR score:____
Did the baby have any problems starting to breathe? { }Y { }N
Did the baby have any problems while in the hospital?{ }Y { }N
If so, what?_____
Treatments?_____

PAST MEDICAL HISTORY

Date of last checkup?_____
Date of last dental checkup?_____
Has your child had any allergic reactions to medicines, insect bites, or food? { }Y { }N
If so, what? _____
Does your child have any other alleriges? { }Y { }N
If so, what? _____
Has your child had any reactions to immunizations? { }Y { }N
If so, what? _____
Any hospitalizations other than birth? { }Y { }N
If so, when and for what? _____
Any serious injuries? { }Y { }N
If so, what? _____
Any medications taken regularyly? { }Y { }N
If so, what? _____

FAMILY HISTORY

Is mother in good health? { }Y { }N
If no, state problem:_____
Is father in good health? { }Y { }N
If no, state problem:_____
Other children (if any):

Name	Age	Health Problems

Check any of the following for which there is a family history:

{ } Anemia	{ } Asthma	{ } Allergies
{ } Diabetes	{ } Hypertension	{ } Heart Trouble
{ } Mental Illness	{ } Drug Abuse	{ } Alcohol Abuse
{ } Thyroid Probelems	{ } Cancer	{ } Obesity

FEEDING & NUTRITION

Is your child's appetite usually good? { } Y { }N
Is it good now? { } Y { }N
Was/is the baby breastfed? { } Y { }N If yes, for how long? _____
If bottle fed, which formula? _____
Age of introduction of solid food? _____
Sever colic or feeding problems? { } Y { }N
If yes, what? _____
Does your child take vitamins? { } Y { }N
If yes, what type? _____
Any food intolerance? { } Y { }N
If yes, which foods? _____

REVIEW OF SYSTEMS

{ } Frequent ear infections
{ } Eye problems
{ } Teeth problems
{ } Frequent colds or sore throats
{ } Asthma, pneumonia, or reccurent cough
{ } Heart condition or disease
{ } Urinary or bladder infections
{ } Diarrhea, constipation, or bowel problems
{ } Convulsions or nervous system problems
{ } Eczema, hives or other skin conditions
{ } Anemia (now or in the past)
{ } Hearing problems
{ } Speech Problems
List any other medical problems:_____
_____

For teenage girls:

Age beginning breast development: _____
Age first menses: _____
Are menses regular? { }Y { }N

DEVELOPMENT/BEHAVIOR

At what age did your child : Sit alone_____ Walk alone____
Make short sentences (2-3 words)_____
Did your child say any words by 18 months? { }Y { }N
Does your child have trouble sleeping? { }Y { }N
What school does your child attend? _____
What grade is he/she in?_____
Does your child have any trouble in school? { }Y { }N
Any problems with reading or math? { }Y { }N
Does your child get along with other children? { }Y { }N
Circle any of the following with which your child has problems: naps, biting, thumb sucking, bed wetting, toilet training, nightmares, night terrors, bad temper, hyperactivity, trouble concetrating, disciplinary issues, destructive behavior
Other:_____

SAFETY/ENVIRONMENT

Do you live in a { }house { } apartment { } mobile home
What type of heating do you have? _____
Temperature of your homes hot water heater? _____
Are there any smoke alarms in your house? { }Y { }N
Does your child always use a car seat/belt when in the car? { }Y { }N

{ } Learning Problems { } Ear Disease

Have any of your children died? { }Y { }N
How did you hear about DVPA?
{ } Advertisement { } Facebook/Social Media { } Family/Friend
{ } Other

Are there any smokers in you home? { }Y { }N
How old is your house or apartment?_____
Pets? { }Y { }N If yes, what type?_____
Does your child wear a helmet when riding a bicycle? { }Y { }N
Has your child been checked for lead? { }Y { }N
Does your child smoke? { }Y { }N

