Delaware Valley Pediatric Associates • Patient History Questionnaire

PARENTS

Parent #1's Name _____ Age _____
Occupation _____
Parent #2's Name _____ Age _____
Occupation _____
If parents work outside 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? _____ wks
Birth weight: ____ lbs ____ oz Length: _____ in APGAR score: _____
Did baby have any problems starting to breathe? [ ] Y [ ] N
Did baby have any problems while in the hospital? [ ] Y [ ] N
If so, what? _____
Treatments? _____

PAST MEDICAL HISTORY

Date of last check up? _____
Date of last dental check up? _____
Has your child had any allergic reactions to medications, insect bites, or food? [ ] Y [ ] N If so, what? _____
_____
Does your child have any other allergies? [ ] Y [ ] N
If so, what? _____
Has your child had any reactions to immunizations? [ ] Y [ ] N
If so, which ones? _____
Any hospitalizations other than birth? [ ] Y [ ] N
If so, when and for what? _____
_____
Any serious injuries? [ ] Y [ ] N If so, what? _____
_____
Any medications taken regularly? [ ] Y [ ] N
If so, what? _____
_____

FAMILY HISTORY

Is parent #1 in good health? [ ] Y [ ] N
If no, state problem: _____
Is parent #2 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 Problems	[ ] Cancer	[ ] Obesity
[ ] Learning Problems	[ ] Ear Disease	

Have any of your children died? [ ] Y [ ] N

FEEDING AND 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? _____
Severe 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

Does your child suffer from any of the following (check all that apply)?

- Frequent ear infection [ ]
- Eye problems [ ]
- Teeth problems [ ]
- Frequent colds or sore throats [ ]
- Asthma, pneumonia, or recurrent 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 of age? [ ] Y [ ] N
Does your child have any 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 well 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 concentrating, disciplinary issues, destructive behavior, other:_____

SAFETY/ENVIRONMENT

Do you live in a [ ] private house [ ] apartment [ ] mobile home
What type of heating do you have? _____
Temperature of your home's water heater? _____
Are there smoke alarms in your house? [ ] Y [ ] N
Does your child always use a car seat/belt when in the car? [ ] Y [ ] N
Are there any smokers in your home? [ ] Y [ ] N
How old is your house or apartment? _____
Problems with the condition of your house? [ ] Y [ ] N
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

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[ ] Other: _____