



Pediatric Health Information Questionnaire

Patient name: _____ Date: ____/____/____

Date of birth: _____ Age: _____ ☐ New patient ☐ Established patient

General Information

Who is completing this health form? _____

What is your relationship to the patient? _____

What is your preferred language for health care information? _____

What is the best way for the office to contact you? ☐ Phone ☐ Email ☐ Text ☐ Other

What is your preferred method of communication? ☐ Verbal ☐ Sign language ☐ Written ☐ Nonverbal ☐ Other

Interpreter required? ☐ Yes ☐ No

Does the patient have any disabilities or health limitations (e.g. blindness/hearing impairment)? ☐ Yes ☐ No

If yes, please list: _____

Allergies

Is the patient allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

Medications

List all medications the patient takes on regular basis (include over-the-counter, herbal or natural remedies)

Birth History

Pregnancy:

Medical problems? ☐ Yes ☐ No If yes, please list. _____

Hospital: _____

Pregnancy complications:

☐ None ☐ Gestational diabetes ☐ Fewer than three prenatal visits ☐ Multiple gestation

☐ Pregnancy induced hypertension ☐ Placental abruption ☐ Placenta previa ☐ Rh ☐ Sensitization

Maternal substance use during pregnancy:

☐ Smoking ☐ Alcohol use ☐ Medications ☐ Recreational drugs ☐ Other

Delivery:

☐ Normal ☐ Prolonged ☐ Difficult ☐ Vaginal ☐ C/Section ☐ Breech ☐ VBAC ☐ Other

Newborn:

☐ Full term ☐ Premature If premature, by how many weeks? _____

Date of birth _____ Time of birth _____ Birth weight _____

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Birth History

Newborn complications:

- ☐ Feeding problems ☐ Jaundice ☐ Breathing problems ☐ Fever ☐ Anemia
☐ Glucose problems ☐ Antibiotic therapy ☐ NICU admission ☐ Other ☐ Group B strep

Newborn leaving hospital:

Discharge date: ___/___/___ Discharge weight _____ Problems in nursery? ☐ Yes ☐ No

PKU before discharge? ☐ Yes ☐ No Date: ___/___/___ Time: _____

Feeding:

Formula? ☐ Yes ☐ No If yes, formula type? _____

Breast? ☐ Yes ☐ No If yes, how long? _____

Medical illnesses or conditions (list any chronic conditions the patient has been diagnosed with):

Family History

Please indicate if the patient's blood relative(s) have had/currently have the following:

	Father	Mother	Grandparents	Aunt/Uncle	Siblings
Allergies					
Immunodeficiency					
Drug problems					
SIDS					
Birth defects					
Developmental delay					
Blindness					
Deafness					
Cystic fibrosis					
Muscular dystrophy					
Cancer					
Ulcer/heartburn					
Blood disease					

	Father	Mother	Grandparents	Aunt/Uncle	Siblings
Sickle cell disease					
Diabetes					
Hepatitis					
Tuberculosis					
Asthma					
High cholesterol					
Heart disease					
High blood pressure					
Kidney or bladder problems					
Seizures/convulsions					
Migraine					
Sudden death in family younger than age 55					

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History/Hospitalizations/Medical Devices

Please list any surgery or procedure and the year it was performed:

Please list any hospitalizations and the year they occurred:

Has the patient ever had a transfusion? ☐ Yes ☐ No

If yes, did the patient have a reaction or problem with the transfusion? ☐ Yes ☐ No

Social History

Does the patient smoke? ☐ Yes ☐ No Does anyone smoke at home? ☐ Yes ☐ No

Does the patient drink alcohol? ☐ Yes ☐ No Is there alcohol abuse in your household? ☐ Yes ☐ No

Does the patient use drugs? ☐ Yes ☐ No Is there substance abuse in the patient's household? ☐ Yes ☐ No

Is the patient currently in school/daycare? ☐ Yes ☐ No If yes, what is the patient's grade level? _____

Does the patient have school concerns? ☐ Yes ☐ No

If yes, check the patient's concern. ☐ Learning ☐ Social ☐ Communication ☐ Health ☐ Cultural ☐ Other? _____

Does the patient regularly exercise? ☐ Yes ☐ No Times per week: ☐ 1 to 2 ☐ 3 to 4 ☐ 5 to 6 ☐ Daily

Tell us about the patient's nutrition/health: _____

Does the patient eat a healthy diet? ☐ Yes ☐ No Is the patient on a special diet? ☐ Yes ☐ No

If yes, please explain _____

What is the patient's appetite level? ☐ Good ☐ Fair ☐ Poor Does the patient take vitamins/supplements? ☐ Yes ☐ No

If yes, please list: _____

Tell us about the patient's home environment.

☐ House ☐ Apartment ☐ Other ☐ Single parent

Who lives in the household with the child? ☐ Mother ☐ Father ☐ Siblings ☐ Others (Please list) _____

Does the patient feel safe at home? ☐ Yes ☐ No If no, does the patient have a safe place to go? ☐ Yes ☐ No

Are there situations of injury/abuse/neglect in the patient's household? ☐ Yes ☐ No

Have agencies/others been notified? ☐ Yes ☐ No Does the patient have family/friends available to help? ☐ Yes ☐ No

Is there a concern for family members at home? ☐ Yes ☐ No Does the patient have any sleeping problems? ☐ Yes ☐ No

Does the patient use alternative healthcare? ☐ Yes ☐ No Is the patient sexually active? ☐ Yes ☐ No

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Systems Review

Please indicate items that have been ongoing or a recent significant change.

Yes No

General

- ☐ Excessive colic
- ☐ Fatigue/lethargy
- ☐ Fever
- ☐ Unexplained weight loss

Eyes

- ☐ Drainage/discharge
- ☐ Glasses/contacts
- ☐ Redness or watering
- ☐ Styes
- ☐ Vision concerns
- ☐ Eye crossing

Ears

- ☐ Difficulty hearing
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Frequent infections
- ☐ Hearing concerns

Nose/Sinuses

- ☐ Chronic runny nose
- ☐ Nose bleeds
- ☐ Nasal stuffiness
- ☐ Sinus trouble

Mouth/throat

- ☐ Dental defects
- ☐ Sore throat
- ☐ Large tonsils

Cardiovascular

- ☐ Murmur
- ☐ High cholesterol
- ☐ Chest pain
- ☐ Excessive fatigue with exercise

Psychiatric

- ☐ Attention problems
- ☐ Depression
- ☐ Moodiness
- ☐ Sleep disturbances

Yes No

Musculoskeletal

- ☐ Broken bones
- ☐ Hip problems
- ☐ Joint swelling
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches

Skin

- ☐ Dry skin
- ☐ Moles/birthmarks
- ☐ Pale skin color
- ☐ Recurrent rashes
- ☐ Jaundice
- ☐ Eczema

Respiratory

- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hoarseness
- ☐ Wheezing
- ☐ Apnea/breath holding
- ☐ Trouble breathing with exercise

Allergic/immunologic

- ☐ Frequent infection
- ☐ Recurrent hives
- ☐ Sneezing
- ☐ Hay fever

Gastrointestinal

- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Feeding difficulties

Genitourinary

- ☐ Abnormal discharge
- ☐ Blood in urine
- ☐ Pain urinating
- ☐ Burning
- ☐ Bed wetting/incontinence
- ☐ Frequent urination

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Systems Review

Please indicate items that have been ongoing or a recent significant change.

Yes No

Blood/lymph

- ☐ ☐ Anemia
- ☐ ☐ Easy bruising
- ☐ ☐ Excessive bleeding
- ☐ ☐ Large lymph nodes

Neurological

- ☐ ☐ Seizures/convulsions
- ☐ ☐ Tremor
- ☐ ☐ Weakness/paralysis
- ☐ ☐ Limb paralysis
- ☐ ☐ Dizziness
- ☐ ☐ Fainting spells
- ☐ ☐ Migraine
- ☐ ☐ Frequent headaches

Endocrine

- ☐ ☐ Excessive eating
- ☐ ☐ Excessive drinking
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance

Yes No

Reproductive (flex for by gender)

Female:

Date of last period: _____

- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal itching/burning
- ☐ ☐ Irregular periods
- ☐ ☐ Painful periods
- ☐ ☐ Spotting between periods

Male:

- ☐ ☐ Swelling of the scrotal sac/testes
- ☐ ☐ Testicular pain
- ☐ ☐ Penile discharge

Comments: _____
