



We put your health first

Pediatric Health Questionnaire

Child's Name: _____ DOB: ____/____/____ Age: _____

Parent/Guardian Name(s): _____

Previous Physician(s): _____

Medicines/Vitamins: _____

Allergies/Adverse Reactions: _____

Please make sure we have your child's immunization record. Bring a copy to your child's next visit or fill out a release form in the office today so that New West Physicians can obtain it from your child's previous health care provider(s).

PREGNANCY & BIRTH

Place of birth: _____

Delivery by: Vaginal Caesarean

If Caesarean, Why? _____

Birth weight: _____ Birth length: _____

Was child premature? Yes No

If so, how early? _____

Was child adopted? Yes No

DENTAL/EYE HISTORY

Has child seen by a dentist? No Yes

Date of last visit: _____

How often? _____

Has child seen an eye doctor? No Yes

Date of last visit: _____

Does child have glasses or contacts? No Yes

EXPOSURE / HABITS

Does your child live in or regularly visit a house built before 1950? Yes No

Do any household members smoke? Yes No

TV-hours per day _____

Computer – hours per day _____

Video games – hours per day _____

SCHOOL HISTORY

Does your child attend school/preschool? Yes No

Current grade _____ School _____

Any concerns about school performance?

Any concerns about relationship with:

Teachers Yes No

Peers Yes No

Sports/exercise: Type? _____

How often? _____

HEALTH HISTORY

If your child has ever had any of these problems, please write the age at which the problem occurred or started.

- _____ Asthma
- _____ Acne
- _____ Bedwetting
- _____ Behavior problems or behavioral disorder
- _____ Bladder / kidney infection
- _____ Broken bones
- _____ Chicken pox
- _____ Concussion
- _____ Depression / anxiety
- _____ Developmental delays
- _____ Diabetes
- _____ Eye or vision problems
- _____ Emotional problems
- _____ Frequent ear infection
- _____ Genetic disorder
- _____ Hearing problems
- _____ Frequent headaches
- _____ Heart problems or murmur
- _____ Learning problems
- _____ Overweight / obesity
- _____ Scoliosis
- _____ Seizures
- _____ Skin problems
- _____ Sleep problems
- _____ Speech difficulties
- _____ Recurrent stomach pain
- _____ Thyroid problems
- _____ Other: _____



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HEALTH HISTORY Cont.

Has your child ever been hospitalized or had surgery?

Yes No

If yes, please explain (What for? When?):

Does your child see any specialists? If so, please list each doctor's name and what your child sees him/her for.

Any worries about your child's growth or development compared with his or her peers?

SOCIAL HISTORY

Who does your child live with? Please include the ages of other children in the household(s). If there are custody arrangements, please describe.

Is there anything you would like to discuss during your child's visit today?

FAMILY HISTORY

Please indicate any deaths of the child's immediate family members:

Please indicate family members (child's parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Abbreviations for relatives:

M = mother

F = father

S = sister

B = brother

MGM = maternal grandmother (mother's mother)

MGF = maternal grandfather (mother's father)

PGM = paternal grandmother (father's mother)

PGF = paternal grandfather (father's father)

MA = maternal aunt (mother's sister)

MU = maternal uncle (mother's brother)

PA = paternal aunt (father's sister)

PU = paternal uncle (father's brother)

YES	WHO?	CONDITION	YES	WHO?	CONDITION
		Heart attack			Anemia
		High blood pressure			Cancer: what type?
		High cholesterol			Anxiety / depression
		Stroke			Epilepsy / seizures
		Asthma			Glaucoma
		Tuberculosis			Alcoholism / other addiction
		Liver disease			Diabetes
		Kidney disease			Thyroid
		Developmental delay/ mental retardation			Genetic disorder (specify):
		Other:			Other: