New West PHYSICIANS

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?

ForFemalePatientsOnly
Age at first menstrual period

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	MGM = maternal grandmother (mother's mother)	MA = maternal aunt (mother's sister)
F = father	MGF = maternal grandfather (mother's father)	MU = maternal uncle (mother's brother)
S = sister	PGM = paternal grandmother (father's mother)	PA = paternal aunt (father's sister)
B = brother	PGF = paternal grandfather (father's father)	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: