Stonebrook Family Medicine

Pediatric Questionnaire

Dr. Mona Chacko

Patient's name:_____DOB:_____ Today's Date:_____

Mother's name:_____ Age:_____

Father's name:_____Age:_____

Are parents married/divorced/separated? Who does child live with?

_____

A. PREGNANCY AND BIRTH:

1. Was the baby on time? Y N
2. What was the birth weight? _____lbs._____oz
3. Did the baby have trouble starting to breathe? Y N
4. Did the baby have any trouble while in the hospital (jaundice, infection, other?) Y N

B. PAST MEDICAL HISTORY:

1. Date of last Dental check-up? _____
2. Has child had **allergic** reactions to any medications, food, insect bites? Y N
   Which Ones? _____
3. Any hospitalizations other than for birth? Y N
4. Any surgeries?_____
   _____
5. Is child on medications? _____
   _____

C. DEVELOPMENT/BEHAVIOR:

1. At what age did child sit alone? _____
2. At what age did child walk alone? _____
3. Did your child say words by the time he/she was 1 years old? Y N
4. Does child have trouble sleeping? Y N
5. What grade is child in? _____
6. What school/daycare?_____
7. Does child get along with other children? Y N
8. Does your child have any of the following?
   ___Bed wetting ___Bad temper
   ___Problems w/discipline ___Nightmares
   ___Speech Problems ___Other

D. SAFETY/ENVIROMENT

1. Is there a working smoke alarm on each floor in the house? Y N
2. Does your child always use a car seat/ seat belt when riding in the car? Y N
3. Are there any smokers in the household? Y N
4. Does your child always wear a helmet when riding his/her bicycle or rollerblading? Y N

E. FEEDING AND NUTRITION:

1. Is child's appetite usually good? Y N
2. Does he/she take vitamins? Y N

F. PLEASE GIVE US A COPY OF IMMUNIZATION RECORDS

G. REVIEW OF SYMPTOMS:

1. Any ear trouble or hearing loss? Y N
2. Any eye problems? Y N
3. Has child had problems with teeth/gums Y N
4. Does child have frequent colds/sore throats? Y N
5. Is there asthma, pneumonia, recurrent cough? Y N
6. Does your child have a heart murmur or any heart problems? Y N
7. Does child have problems with urination? Y N
8. Does child have problems with diarrhea/ constipation? Y N
9. Have there been any convulsions or other problems with nervous system? Y N
10. Any eczema, hives, other skin conditions? Y N
11. Has child ever been anemic? Y N
12. Please list any other medical problems:
    _____

If you (P) or a member of your family, Father (F), Mother (M), Sibling (S), or Children (C), or Grandparents (GP), have had the following illnesses or problems, list the appropriate initials.

H. FAMILY HISTORY:

(mark if present in any of your child's siblings, aunts/uncles, first cousins)

___Spina Bifida
___Cancer (type)_____
___Cleft lip/palate
___Hearing loss/deafness
___Heart disease/defect
___Neurofibromatosis
___Mental Retardation
___Neurological Disorder
___Mental Illness
___Tuberculosis
___Hay fever
___Sickle Cell anemia
___Muscle disorder
___Skin disease
___High blood pressure
___Urinary tract abnormality
___High cholesterol/triglycerides
___Brain abnormalities (includes Hydrocephaly)
___Anemia (includes Thalassemia)
___Patient's mother was exposed to DES
___Other birth defects/malformations/problems?
___Vision/Eye Problems
___Cerebral Palsy
___ADD/learning disorder
___Convulsions
___Infertility
___Limb defects
___Down Syndrome
___Cystic Fibrosis
___Short stature (<5')
___Diabetes
___Drug/Alcohol problems
___Bleeding disorder
___Kidney disease
___Genital Abnormality
___Asthma
___AIDS (HIV)
___Chromosome abnormality

Please list age, sex, and health problems of brothers and sisters (are they living?):

_____