

PEDIATRIC HEALTH QUESTIONNAIRE

Patient's name: _____ Today's Date: _____ DOB: _____ Age: _____
Your insurance company requires the following information for proper payment. Please fill out completely.

Reason for today's visit: _____

- 1) Timing of problem- continuous or intermittent (comes and goes)
- 2) Quality of problem-sharp, dull, irritating, burning, throbbing or (other) _____
- 3) Duration of symptoms\ problems _____ days/weeks/months/years
- 4) Severity of symptoms/problems- mild, moderate, severe
- 5) Modifying factors
 Things that make it worse: _____
 Things that make it better: _____
- 6) Symptoms: _____
- 7) Previous Treatment- Have medications been tried for these symptoms? YES/ NO
 If yes, what medications: _____
 Other form of therapy / treatment: _____
- 8.) Have any x-rays, CAT scans, MRI, or lab work been done in the last year related to the current illness? Yes / No
 When and Where: _____

Does your child have problems with any of the following systems? If yes, please explain.

- | | |
|----------------------|----------------------------|
| Eyes: Y / N _____ | Urinary Tract: Y / N _____ |
| Ears: Y / N _____ | Muscles/bones: Y / N _____ |
| Nose: Y / N _____ | Skin: Y / N _____ |
| Throat: Y / N _____ | Neuro/Psych: Y / N _____ |
| Heart: Y / N _____ | Mental Status: Y / N _____ |
| Lungs: Y / N _____ | Endocrine: Y / N _____ |
| Stomach: Y / N _____ | Blood: Y / N _____ |
| Other: _____ | |

Medications

Please list medication and dosage: _____

Medication Allergies: YES or NO **Latex Allergy:** YES or NO **Environmental Allergies:** YES or NO

If yes, please list and describe reaction: _____

Birth History: please circle all that apply

Healthy pregnancy / Vaginal delivery / Cesarean Section / Premature / Intensive Care Unit / Oxygen / IV Antibiotics / Jaundice / Birth Defects _____ Other: _____

Past Medical History:

Anesthesia complications Asthma Bleeding problems Diabetes Thyroid problems

Immunization History:

Up to Date / missed shots / reason: _____

Past Surgical History-Please list past surgeries/operations and when they occurred: _____

Family History- Do any immediate family members have the following health problems?

If yes please circle and state the relationship.

Anesthesia complications Allergies Asthma Bleeding problems Cancer (type) _____
Diabetes Hearing loss Heart Disease Seizures Thyroid disorders Genetic diseases

Other: _____

Social History- (please fill out completely)

Who child lives with- circle all that apply: Biological Parents / Single Parent: Mother / Father / Adopted / Foster Parent /

Other: _____ / Number of Siblings: _____ Household Members: _____

Care Giver or Guardian Information: N/A or Yes _____

Home with parent / Day care / Days a week in day care _____ / Preschool / # of children in class _____ Grade in School _____

Exposure to Cigarette, Cigar, Pipe (even if smoking outside the home) by Parents / Caretakers _____

PARENT / GUARDIAN SIGNATURE _____ DATE _____