DP Pediatric, LLC

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PEDIATRIC HEALTH HISTORY QUESTIONNAIRE - OVER ONE YEAR

This questionnaire will become part of your child's Medical Record - Please fill out completely

Date: _____ Child's Name: _____ _____ _____
Last Middle First

Sex: M ☐ F ☐ Birth Date: _____ Child's Age at completion of this form _____

Record # _____ Social Security # _____-_____-_____

Home Address: _____ City _____ State _____ Zip:_____

Tel. No. (Home) _____ Work (Mom) _____ Work (Dad) _____

Primary Care Physician: _____

I. PRENATAL and/or AT BIRTH - With this child, were there any problems during:

Your pregnancy? Yes ☐ No ☐	Your labor and delivery? Yes ☐ No ☐

-- Additional Data --	
Term of Pregnancy:	Normal ☐ ; Reduced ☐; Delayed ☐ ; Pregnancy Term _____ weeks
Labor & Delivery Status:	Normal ☐ or C-Section ☐ ; If C-Section delivery, give reason for it -
The New Born Status at Birth:	Jaundice – Yes ☐ No ☐; Difficulty Breathing – Yes ☐ No ☐ ; Other Conditions - Yes ☐ No ☐ ; If "yes" to any, please explain: _____
Your child's birth weight:	_____ lbs. _____ ozs.

II. DEVELOPMENT

At what age did your child (?):

Smile		Say sentences		Potty training (bladder) day	
Sit		Climb stairs			
Walk		Ride a tricycle		Potty training (bladder) night	
Say words		Potty trained (bowel)			

Does your child have any school problems? Yes ☐ No ☐ If yes, please explain: _____

Is your child in a special class? Yes ☐ No ☐ If yes, type of class: _____

III. HEALTH

Is your child allergic to any medication or food? Yes ☐ No ☐ If yes, state medication or food(s): _____

What happens when he/she takes it?

_____ conti.

_____

Has your child ever had a major illness? Yes ☐ No ☐ If yes, explain: _____

_____

Has your child had any surgeries? Yes □ No □If yes, when & for what? _____

_____

Has your child ever been admitted to a hospital (overnight)? Yes ☐ No ☐ If yes, Hospital Name & Location?

_____

Has your child any of the following (Please check √ all applicable):

Allergies or Hay Fever		Chronic Diarrhea		Eat Strange Things (Paint Chips, Newspapers. etc.)	
Asthma or Wheezing		Hepatitis			
Eczema		Repeated Stomach Aches		Mental Retardation	
Food Intolerance		Bed Wetting		Muscle Weakness	
Hives		Kidney Disease		Recurrent Headaches	
Reaction to Bee/ Wasp Sting		Urinary Infection		Seizures or Convulsions	
Vaginal Bleeding		Heart Disease		Abnormal Bleeding	
Cystic Fibrosis		Heart Murmur		Blood Problems or Anemia	
Recurrent Pneumonia		Rheumatic Fever		Sickle Cell Disease	
Hearing Loss		Swollen Joints		Cancer	
Recurrent Ear Infection		Cerebral Palsy		Bone Problems	
Celiac Disease		Crossed Eyes		Diabetes	
Chronic Constipation		Measles			
Chicken Pox					

IV. <u>EMOTIONAL DEVELOPMENT</u>

Does your child have (Please check √ all applicable):

Temper Tantrums		Trouble with Police		Behavior Problems in School	
Day Dreaming		Excessive Distractibility		Excessive or Unusual Eating	
lack of Friends		Frequent Accidents		Lack of Appetite	
Soiling Self		Excessive Quietness		Unreasonable Fears	
Frequent Fights		Depression		Insomnia	

VI. <u>FAMILY</u>

Does anyone in your or your spouse's family have any of the following (Please check):

Cystic Fibrosis		Arthritis		Kidney Disease	
Anemia		Deafness		High Blood Pressure	
Sickle Cell Disease		Early Blindness		Cancer	
Asthma		Convulsions		Hormone (e.g., Thyroid Problem)	
Hay Fever		Mental Retardation		Muscular Dystrophy	
Diabetes		Mental Illness		Died Young	
Hear Disease (under 60 years of age)		Sever Depression			

Other – Explain: _____

_____

What is the ethnic background of the child's father? _____ __ conti.

What is the ethnic background of the child's mother? _____

VII. SOCIAL

Please respond to the following in relation to the child:

Number of people staying at home _____

Do both parents stay in the same house? _____ ; If no, with whom does the child live? _____

How many other people sleep in child's room? _____

Is your housing adequate? _____

Do both parents work? _____ ; Occupations: _____

_____

Does anyone in the house smoke? _____

Are there any other problems that we should know about your child's health or that are troubling you?

_____

_____

_____

_____

_____

If the caretaker of your child is other than yourself, please state who besides your may authorize care for your child:

_____ _____

Name: First, MI, Last Address (Line 1)

_____ _____

Relationship to the Child Address (Line 2)

_____

Phone Number

Agreement: In order to provide proper care and monitor child's growth, the Parent agrees to inform the Primary Care Physician at DP Pediatrics, LLC, if there is a change in any of the information.

Signature: _____ Date: _____

_____

Parent/Guardian Print Name

Reviewed by Physician: _____ Date: _____