**PEDIATRIC  HEALTH/MEDICAL HISTORY QUESTIONNAIRE**

**Name of Child**

Birthday \_\_\_\_\_\_\_\_\_\_ Male ☐       Female☐

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home phone \_\_\_\_\_\_\_\_\_\_\_\_. Work/Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Problem/Concern:**

Please explain about any health problem that your child has now

Yes☐ No☐ Is your child now under regular medical care for any conditions? If yes, what is the condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No ☐ Does your child have allergies (foods, pet, insects)? If yes, please list: \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has your child experienced any of the following?

☐ asthma   ☐ seizure   ☐ diabetes   ☐ speech problem  ☐ respiratory disorder  ☐ digestive problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐kidney disease   ☐ heart condition   ☐ serious illness    ☐ serious accident   ☐ surgery

☐ head injury ☐ hospitalization    ☐ other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No ☐ Is your child taking any medications for above condition?

Yes☐ No ☐ Does your child requires shoe inserts or braces? If yes, why

Yes☐ No ☐ Does your child requires a wheelchair or stroller for getting around? (explain): \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No ☐ Does your child currently take a bottle? If so when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last completed physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

by MD/PA/ANP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

☐ Takes medicine on a daily basis for (list medical condition): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medicine      Dose/Route     Time given

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   To have any prescription medication in school, we require that the medication form be completed by the parent and healthcare provider: MD/DO/ANP/PA & in a properly labeled pharmacy container.  To have an Over-The-Counter medication at school, parent must complete a separate form and provide medication in an original container.

**\*\*\*\*\*\*\*. Homeopathic remedies cannot be given at school.** \*\*\*\*\*\*\*

**Hearing Problems:**     Yes☐ No☐ If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ frequent ear infection?   ☐as an infant ☐more recently  ☐ has ear tubes, number of surgeries for ear tubes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ problem with hard wax? ☐ Hearing aid(s)?  ☐Audiology evaluation?

☐ Documented hearing loss

Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last exam date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision Concerns:**      Yes☐     No☐       If YES explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No ☐ wears glasses? If prescription is not current, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Yes☐ No ☐ any vision concerns? If so, please explain : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes☐ No ☐ has had a full eye exam, performed by an eye doctor (name) Dr.

Yes☐ No ☐ had eye surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_    Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child has had professional hearing and/or vision evaluations, please provide the Release of Information form attached.

**Pregnancy and Birth History:**

Yes☐ No☐ Did you experience problems (bleeding, high blood pressure, early contractions, etc.) during this pregnancy?   Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Yes☐ No☐ Did you take medications during this pregnancy?  What and Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No☐ Did you smoke?  How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No☐ Did you drink beer, wine, alcohol? I f so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes☐ No☐ Any use of recreational drugs during pregnancy? What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Yes☐ No☐ Were there any difficulties during delivery? What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Newborn History:**

Yes☐ No☐ Was your child born on time? (Between 38-42 weeks)? If not, how early: \_\_\_\_\_\_\_\_\_

Yes☐ No☐ Caesarian section, If Yes, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No☐ Did your child go home with the mother? If not, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No☐ Did your child need oxygen after birth? If so, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No☐ Did your child turn yellow (jaundice) enough to be treated? If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes☐ No☐ Did your child has any complications that required a stay in the Neonatal Intensive

Care Unit (NICU)?  Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have any of the following conditions?

☐ Birth defect ☐ neurological disorders ☐ seizures ☐ muscular disorders ☐ chromosomal disorders ☐ Down’s syndrome ☐ Cystic Fibrosis ☐heart problem

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was your child?**

☐ Strong   ☐ floppy ☐fussy ☐ mellow  ☐not gaining weight  ☐hard to calm or sooth

☐ difficult to feed ☐ Other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Early Developmental Milestones:** At what age did your child do the following?

Sit without help \_\_\_\_\_\_\_\_\_\_ months; Crawl \_\_\_\_\_\_\_\_\_\_ months; Walk \_\_\_\_\_\_\_\_\_\_\_\_months; Play with toys \_\_\_\_\_\_\_\_\_\_\_ months Begin to use single words \_\_\_\_\_\_\_\_\_\_ months; Begin to use sentences \_\_\_\_\_\_\_\_\_\_ months; Feed him/herself \_\_\_\_\_\_\_\_\_\_ months;

Dress him/her self \_\_\_\_\_\_\_\_\_\_ months

Use the bathroom/toilet trained? No ☐ Yes ☐ at what age

Do you have any concerns about your child’s development? Yes☐ No☐

If YES explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     **Social & Behavioral History:** Please check any of the following that usually apply

☐ gets along well  ☐ Is always moving   ☐ shares ☐ acts shy  ☐ quick to anger   ☐ acts without thinking   ☐ cries easily      ☐ doesn’t listen    ☐ misunderstands ☐  doesn’t remember instructions ☐ prefers quiet activities ☐  accident prone ☐ tunes out

☐ is not able to sit still and listen to a story for 10 minutes

☐strangers do not understand his/her speech

☐ other concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Professional Services:**

Has your child been seen by any of the following?     ☐Psychiatrist     ☐Psychologist     ☐Social Worker      ☐ Physical Therapist      ☐ Occupational Therapist  ☐ Other specialist (list) \_\_\_\_\_\_\_\_

If yes, please list the name/s and dates seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person parent/guardian (circle one), completing questionnaire (please print):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only

Provider review  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data entered into EMR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_