Pediatric Patient Questionnaire

For children 12 months and older

NAME:

DOB:

INTERPRETER NEEDED? ☐ NO ☐ YES, _____

a. Medications/Allergies

List any **allergy(ies)** and **reaction(s)** you have: ☐ NONE _____

List any medications you are currently taking: ☐ NONE

Medicine:	**Dose:**	**How often:**	3.		
1.			4.		
2.			5.		

b. Personal Health History

Have you ever had or are you being treated for any of the following conditions?

ADHD	☐ NO ☐ YES	Eczema	☐ NO ☐ YES	Depression/Anxiety	☐ NO ☐ YES
Food allergies	☐ NO ☐ YES	Broken or dislocated bone	☐ NO ☐ YES	Blood clots	☐ NO ☐ YES
Seasonal allergies	☐ NO ☐ YES	Reflux/GERD	☐ NO ☐ YES	Mental illness	☐ NO ☐ YES
Anemia	☐ NO ☐ YES	Head injury	☐ NO ☐ YES	**Learning/ Developmental delay**	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Headaches	☐ NO ☐ YES	Autism	☐ NO ☐ YES
Bleeding disorder	☐ NO ☐ YES	Hearing problems	☐ NO ☐ YES	Vision problems	☐ NO ☐ YES
Breathing problems	☐ NO ☐ YES	Ear infection	☐ NO ☐ YES	Snoring at night	☐ NO ☐ YES
Concussion	☐ NO ☐ YES	Prematurity	☐ NO ☐ YES	Other: _____	
Heart Problems	☐ NO ☐ YES	*How early?* _____			
Constipation	☐ NO ☐ YES	Seizures	☐ NO ☐ YES		
Diabetes	☐ NO ☐ YES	Kidney/Urinary tract infection	☐ NO ☐ YES		

When you exercise do you have problems with:

Passing out or feeling like you will pass out	☐ NO ☐ YES
Chest pain or discomfort	☐ NO ☐ YES
Heart skipping beats or racing	☐ NO ☐ YES
Feeling lightheaded or more short of breath than expected	☐ NO ☐ YES
Feeling more tired or short of breath than your friends	☐ NO ☐ YES

Have you ever had surgery:

To remove your tonsils and/or adenoids	☐ NO ☐ YES
To remove your appendix	☐ NO ☐ YES
On your teeth (dental surgery)	☐ NO ☐ YES
To place ear tubes	☐ NO ☐ YES
List any other type of surgeries you had:	☐ NONE

_____

c. Females Only

Have you had a period? ☐ NO ☐ YES

If yes, what age did you start having periods? _____

Please list any problems or concerns about your periods: NONE _____

_____

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d. Family History

Were you adopted ☐ NO ☐ YES

Has anyone in your family ever had *(please provider information for biological parents and siblings only).*

ADD/ADHD	☐ NO ☐ YES	Deafness	☐ NO ☐ YES	**Sudden death**	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Diabetes	☐ NO ☐ YES	Sickle cell disease	☐ NO ☐ YES
Cancer	☐ NO ☐ YES	High cholesterol	☐ NO ☐ YES	Bleeding disorder	☐ NO ☐ YES
Heart Problems	☐ NO ☐ YES	Strabismus/Lazy eye	☐ NO ☐ YES	Blood clots	☐ NO ☐ YES

1. Has any family member or relative died of heart problems or had unexplained or unexpected sudden death before the age of 50 (including drowning, unexplained car accidents, or sudden infant death syndrome)? ☐ NO ☐ YES
2. Does anyone in your family have a pacemaker, implanted defibrillator, or heart rhythm problem? ☐ NO ☐ YES
3. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ☐ NO ☐ YES

e. Social History

Tobacco use (including vape): ☐ NO ☐ YES ☐ FORMER Smokers in family: ☐ NO ☐ YES Smoking allowed in the home: ☐ NO ☐ YES

Mother's Name: _____ Birthdate: _____ Age: _____ Living: ☐ NO ☐ YES

Father's Name: _____ Birthdate: _____ Age: _____ Living: ☐ NO ☐ YES

Does child attend Daycare? ☐ NO ☐ YES

Primary residence: ☐ Mother ☐ Father ☐ Other, _____ Secondary residence: ☐ Mother ☐ Father ☐ Other, _____

Mother's occupation: _____ Father's Occupation: _____ # of siblings: _____

Any concerns about relationships with family/friends/other? ☐ NO ☐ YES

Home type: ☐ Apartment ☐ House ☐ Condominium ☐ Mobile Home (trailer)

Do you drink tap water? ☐ NO ☐ YES

Do you use a helmet when you ride your bike, skate, or skateboard? ☐ NO ☐ YES ☐ N/A

Do you use a car seat? ☐ NO ☐ YES ☐ N/A Do you use a seat belt? ☐ NO ☐ YES

Do you have the following at home:

Carbon monoxide detector ☐ NO ☐ YES

Smoke detector ☐ NO ☐ YES

Firearms ☐ NO ☐ YES

How many hours per day do you spend: Playing sports/exercising? ____ Watching Television? ____ On the computer/internet? ____

f. Dental Health

How many times a day do you brush your teeth? _____

How many times a week do you floss your teeth? _____

Have you seen a dentist in the past year? ☐ NO ☐ YES

Thank you for taking the time to tell us about your health history.

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