Southern Dominion Health System

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Previous or referring doctor:		**Date of last well child check-up (if known) :**

HOUSEHOLD INFORMATION

Name of Parent: ☐ Mother ☐ Father

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Are Parents: ☐ married ☐ divorced ☐ partnered ☐separated

Who is this child's legal guardian? Relationship to child if not a parent?

Who else lives in the home with this child?

Name	Relationship to Child	Age	Any Medical Problems?

Are there siblings not living in the home and not listed above? If yes, please list:	

BIRTH HISTORY

Birth Weight_____ Born at full-term? ☐ yes ☐ no

If Premature- how many weeks was baby at birth? _____

Was the delivery ☐ Vaginal ☐ Cesarean Section

Were there any complications with the delivery? ☐ yes ☐ no

If yes, please describe the complications: _____

_____

Was the initial feedings with ☐ Breast ☐ Bottle
If still breastfeeding, is your baby taking vitamin D? ☐ yes ☐no

During the pregnancy, did the mother use any of the following:

☐ Tobacco
☐ Alcohol
☐ Drugs
☐ Prescribed or over-the-counter medications
If yes, please list_____

_____

_____

List child's prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

GENERAL INFORMATION

Do you consider this child to be in good health?	☐ Yes	☐ No	☐ Not sure
Does this child have any serious illnesses or medical conditions?	☐ Yes	☐ No	☐ Not sure
Has this child ever had any surgeries?	☐ Yes	☐ No	☐ Not sure
Has this child ever spent the night in the hospital?	☐ Yes	☐ No	☐ Not sure
Is this child up to date on vaccinations?	☐ Yes	☐ No	☐ Not sure
Does this child see any specialists?	☐ Yes	☐ No	☐ Not sure
If Yes please list:			
Has this child received any physical therapy or speech therapy?	☐ Yes	☐ No	☐ Not sure
Does (or did) this child ever receive any infant early intervention services?	☐ Yes	☐ No	☐ Not sure
Does this child have an IEP or receive any special services in school?	☐ Yes	☐ No	☐ Not sure
Is this child in school? If yes where? _____	☐ Yes	☐ No	☐ Not sure
Are there people who smoke in your home?	☐ Yes	☐ No	☐ Not sure
Does this child identify as a male or female	☐ Male	☐ Female	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is there a family history of Mental Health Issues? If yes please describe:	☐ Yes	☐ No
Do you think this child feels depressed?	☐ Yes	☐ No
Does this child have problems with eating or with their appetite?	☐ Yes	☐ No
Does this child have trouble sleeping?	☐ Yes	☐ No
Has this child ever received counseling?	☐ Yes	☐ No

Please have your child answer the following two questions if they are 12 years of age or older:

In the past two weeks have you been bothered by little interest of pleasure in doing things?	☐ Yes	☐ No
In the past two weeks have you felt down, depressed or hopeless?	☐ Yes	☐ No

Has this child had any of the following problems?

- ☐ ADHD
- ☐ Alcohol or drug use
- ☐ Allergies (seasonal)
- ☐ Allergies (food)
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Behavior problems
- ☐ Blood Disorders (such as Sickle Cell Disease)
- ☐ Cancer
- ☐ Constipation
- ☐ Developmental Delays
- ☐ Diabetes --- Insulin Dependent
- ☐ Diabetes --- Not on Insulin
- ☐ Ear infections (frequent)
- ☐ GERD/reflux
- ☐ Genetic/metabolic problems
- ☐ Heart Problems
- ☐ Headaches
- ☐ History of abuse or family violence
- ☐ Kidney Disease
- ☐ Learning problems
- ☐ Liver Disease
- ☐ Menstrual Cycle problems
- ☐ Age of first menstrual cycle if applicable_____
- ☐ Seizures
- ☐ Skin problems (eczema, frequent abscesses, MRSA)
- ☐ Sleep problems such as snoring or apnea
- ☐ Tobacco use
- ☐ Thyroid Disorder
- ☐ Urinary Tract Infections
- ☐ Anxiety/Depression

Any other problems not listed: _____

_____

Additional Information

Does this child attend daycare? ☐ Yes ☐ No

Is the parent/guardian of this child currently employed? ☐ Yes ☐ No

If yes- please list: _____

Are there any other specific concerns you would like to address with your provider today?

_____

_____

Parent/Guardian Printed Name_____

Parent/Guardian Signature _____ Date_____

Reviewed by: _____ Date_____