

TODAY'S DATE \_\_\_\_\_

**FAMILY PHYSICIANS GROUP  
PEDIATRIC HEALTH QUESTIONNAIRE**

NAME: Last	First	M.I.	Date of Birth:	Child's Sex:	Child's Grade:
Mother's Name:			Father's Name:		
Number of Siblings and ages:					
<b>PRESENT</b>					
What problem are you here for today?					
Have you seen a doctor before for this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of doctor?	What was the diagnosis?		
<b>PREGNANCY HISTORY</b>					
During pregnancy: <input type="checkbox"/> Smoking <input type="checkbox"/> Alcoholic Beverages <input type="checkbox"/> Infections <input type="checkbox"/> Bleeding <input type="checkbox"/> Medications/Drugs <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Premature Labor Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section    Complications: _____					
<b>NEWBORN HISTORY</b>					
Child's Weight at Birth:    lbs    oz		History of: <input type="checkbox"/> Jaundice <input type="checkbox"/> Infections <input type="checkbox"/> Colic <input type="checkbox"/> Breathing Problems <input type="checkbox"/> Feeding Problems <input type="checkbox"/> Other			
<b>FAMILY HISTORY</b>					
Relationship to Patient		Relationship to Patient		Relationship to Patient	
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Cystic Fibrosis	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Muscular dystrophy	_____	<input type="checkbox"/> Sickle Cell	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Anesthetic Reaction	_____
<input type="checkbox"/> Bleeding Disorder	_____	<input type="checkbox"/> Thyroid Disease	_____	<input type="checkbox"/> Other	_____
<b>HISTORY</b>					
MEDICATION ALLERGIES: (List the drug and the reaction)		CURRENT MEDICATIONS: (include the frequency, and dose if you know them. Include non-prescription drugs, vitamins)			
<b>Surgeries</b>			<b>Other Hospitalizations</b>		
Year	Reason	Hospital	Year	Reason	Hospital
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Glasses	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Frequent "Colds"
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Chronic Skin Rashes
<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Bedwetting over age 3	<input type="checkbox"/> Anemia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Swollen or Painful joints
<input type="checkbox"/> Chronic muscle aches	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Learning disorder	<input type="checkbox"/> Other		
Child Care Outside of the home (explain):					
Child is current on immunizations: <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please provide copy of immunizations					
Does anyone smoke in the home?: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are there guns in the home?: <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>GIRLS ONLY</b>					
Age of first period: _____		<input type="checkbox"/> Heavy Periods <input type="checkbox"/> Spotting <input type="checkbox"/> Painful Periods			
Date of last period: _____		<input type="checkbox"/> Irregular Periods <input type="checkbox"/> Other menstrual Problems			