Patient History Questionnaire (Pediatric)

Patient Name:_____ **DOB**:_____ **Sex**:_____
Primary Care Physician_____ **Referring Physician**_____
Parents' Names:_____
Chief Complaint/Reason for Visit_____

Medical History

Birth History __Vaginal Delivery __Cesarean Delivery # of Weeks Gestation_____

_____
_____
_____

Drug Allergies/Food Allergies/Contact Allergies

List name of substance, what the reaction was and when it occurred

_____
_____
_____

Medication List

Please list **ALL** medications, including over-the counter medications, vitamins, minerals, and supplements
Attach a separate sheet of paper if necessary

Medication **Dosage** **Frequency**

_____
_____
_____
_____
_____
_____
_____
_____

Are you UP TO DATE on your immunizations: Yes/No

Family History

Check any first-degree relatives with following conditions:

Seasonal Allergy:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____
Asthma:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____
Immune Disease:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____
Thyroid Disease:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____
Food Allergy:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____
Drug Allergy:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____
Eczema:	__Mother	__Father	__Sibling	Brother/sister	__Child	Son/Daughter	Other_____

Past Surgeries

List **ALL** past surgeries

Type of Surgery	**Date**	**Reason**

Social History

Please check **ALL** that apply

Grade in School: _____

Tobacco/Smoke Exposure:
__None __Minimal __Frequent

Do you have any pets: Yes/No If yes, what types and how many? _____
Do the pets go into your bedroom: Yes/No

Any other environmental exposures or concerns? _____

Review of Systems

General:
__Chills __Fever __Fatigue __Night Sweats

Skin:
__Hives __Itching __Rash __Swelling __Eczema __Infection __Dry Skin

Eyes:
__Watery Eyes __Eye Pain __Eye Redness __Itchy Eyes __Eye Discharge
__Eye Swelling

Ears, Nose, Throat:
__Ear Discharge __Ear Pain __Ear Swelling __Itchy Ears
__Runny Nose __Nose Bleeds __Itchy nose __Nasal Congestion __Sneezing
__Sinus Pain __Snoring __Itchy throat __Sore Throat __Mucous
__Poor Dental Hygiene __Decreased Sense of Smell __Decreased Sense of Taste

Respiratory:
__Chest Tightness __Cough __Shortness of Breath __Noisy Breathing __Hoarseness
__Wheezing __Nighttime Symptoms __Difficulty Breathing on Exertion

Cardiology:
__Chest Pain __Poor Circulation __High Cholesterol __Hypertension
__Irregular Heart Beat __Heart Murmurs __Swelling of Extremities

Gastrointestinal:
__Abdominal Pain __Black, Tarry Stools __Bloody Stool __Diarrhea __Difficulty Swallowing
__Nausea __Vomiting __Heartburn __Indigestion __Acid Reflux

Genitourinary:
__Bloody Urine __Frequent Urination __Painful Urination

Musculoskeletal:
__Joint Pain __Joint Stiffness __Joint Swelling __Back Pain __Soft Tissue Swelling

Neurological:
__Dizziness __Headaches __Migraines __Numbness __Weakness __Tingling

Psychiatric:
__ADHD __Bipolar Disorder __Anxiety __Depression

Endocrine:
__Cold Intolerance __Heat Intolerance __Dry Skin __Hair Changes __Thyroid Disease
__Weight Changes

Hematology:
__Anemia __Easy Bleeding __Easy Bruising __Blood Clots __Bleeding Gums