Pediatric Patient Medical History Questionnaire

Name ______________________ Age ________ Today's date ________________

Address ______________________________ Home Phone # ______________________
______________________________ Cell # ______________________
Work # ______________________

Ethnic Background ______________________ Religion ______________________

Is child Allergic to any medications or Foods? ☐ yes ☐ No
if so Please list: ____

Number of people living in home ________ Total Children ________ Adults ________
Do other people care for this Child Regularly ? ☐ yes ☐ No

Patient Birth History

Birth Date : ________ Birth Place ________ Birth Weight ________ APGAR ________
Any Complications on Pregnancy (list) ________
Did Mother carry this child for a full 9 months ☐ yes ☐ no

Delivery ☐ Vaginal ☐ C- section

Newborn Problems ____

Family History

Heart Disease	☐	☐	Epilepsy/ Convulsions
High Blood Pressure	☐	☐	Blood Disease
Allergy/ Asthma	☐	☐	Other Inherited Diseases
Tuberculosis	☐	☐	Mental Retardation
Diabetes	☐	☐	Mental Problems
Sickle cell	☐	☐	Other

Relatives name		**Age**	**Medical problems**
Patients mother:			
Patients Father:			
Patients Sister :			
Patients Brother:			

Have any Children Died in your Family ? ☐ Yes ☐ No
If yes then give age and cause of death: ______________________

Has Child had any problems with the following

Heart	☐	☐	Urine / Kidneys
Lung	☐	☐	Teeth
Eyes	☐	☐	Behavior Problems
Repeated Infections	☐	☐	Skin
Digestion	☐	☐	Feet
Allergies	☐	☐	Joints
Convulsions	☐	☐	Ears/ Hearing

Previous hospitalizations or serious illnesses ______________________________
____

Current medications ______________________________
____
____

Patient Name: ______________________ **Date of Birth** ______________________

For your child at what age:

Sat up:		Short Sentences:	
Words:		Bladder	
Walked:		Bowel:	

All Children Names	**Date of Birth**