In order for us to serve you better, please take a few moments to complete this form. Thank you.

# PEDIATRIC PATIENT QUESTIONNAIRE

DATE _____ PCP _____ MR# _____

Name _____ Birthdate _____ Sex: M ☐ F ☐

Mother _____ Birthdate _____ Phone _____

Address _____

Father _____ Birthdate _____ Phone _____

Address _____

Legal Guardian (if other than parent) _____ Phone _____

Address _____

Siblings (names & birthdates) _____

_____

Parents are: Married_____ Single_____ Separated_____ Divorced_____

Members of Household _____

_____

Pets in the home _____ Smokers in the home _____

Well water or city Water _____ Any home built prior to 1950/lead exposure _____

Diet _____ Daycare _____

**ALLERGIES** (drugs, food, pollens, etc.) _____

## FAMILY HISTORY

Do any of the child's close relatives (mother, father, grandparents, brother or sister) have any of the following? (Please list relative)

| | | | |
|---|---|---|---|
| _____ Diabetes | _____ Cancer | _____ Allergic Disease | _____ Seizures |
| _____ Heart Disease | _____ Bleeding Disorders | _____ Asthma | _____ Kidney Disease |
| _____ High Blood Pressure | _____ Sickle Cell Trait | _____ Cystic Fibrosis | _____ Alcoholism |
| _____ High Cholesterol | _____ Depression | _____ Tuberculosis | _____ Depression/Mental Illness |

## BIRTH HISTORY

Length of Pregnancy _____ Complications _____

Type of Delivery _____ APGAR Scores _____/_____ Weight _____ Length _____

Complications during labor or delivery _____

Problems in the nursery _____

Type & length of feeding (breast/formula) _____ Type of formula _____

## DID THE CHILD HAVE ANY OF THE FOLLOWING PROBLEMS DURING THE FIRST FEW MONTHS OF LIFE?

| | | | |
|---|---|---|---|
| ☐ Jaundice | ☐ Anemia | ☐ Breathing difficulty | ☐ Other (please list) |
| ☐ Trouble feeding | ☐ Seizures | ☐ Blue spells | _____ |
| ☐ Severe colic | ☐ Infections | ☐ Required oxygen | _____ |