West Plano Pediatrics, P.A.

PATIENT NAME: _____

DATE OF BIRTH: _____

PEDIATRIC HEALTH QUESTIONNAIRE

BIRTH HISTORY

CHILD'S BIRTH WEIGHT: _____ DURATION OF PREGNANCY: _____

ANY COMPLICATIONS DURING PREGNANCY? Y N IF YES, PLEASE SPECIFY: _____

_____

TYPE OF DELIVERY: _____ PLACE OF DELIVERY: _____

ANY MEDICATIONS, SMOKING, OR DRUGS DURING PREGNANCY? Y N

ANY PROBLEMS WITH LABOR/DELIVERY? Y N IF YES, PLEASE SPECIFY: _____

_____

LENGTH OF STAY IN NURSERY/NICU: _____

MEDICAL INFORMATION REGARDING PATIENT

ANY MAJOR ILLNESS/HOSPITALIZATION? Y N IF YES, PLEASE SPECIFY: _____

_____

ANY SURGERY? Y N IF YES, PLEASE SPECIFY: _____

_____

ANY ACCIDENTS/INJURIES? Y N IF YES, PLEASE SPECIFY: _____

_____

ANY SUPPLEMENTS OR MEDICATIONS TAKEN REGULARLY? Y N

IF YES, PLEASE SPECIFY: _____

ANY KNOWN DRUG ALLERGIES? Y N IF YES, PLEASE SPECIFY: _____

ANY KNOWN FOOD ALLERGIES? Y N IF YES, PLEASE SPECIFY: _____

DEVELOPMENTAL HISTORY

DO YOU THINK YOUR CHILD IS UP TO DATE WITH PEERS? Y N

CURRENT SCHOOL GRADE: _____ SPECIAL CLASSES? Y N

FAMILY HISTORY: INCLUDE ONLY CHILD'S PARENTS AND SIBLINGS

☐ HIGH CHOLESTEROL/HEART DISEASE/HIGH BLOOD PRESSURE ☐ DIABETES ☐ CANCER

☐ ALLERGIES/ASTHMA/ECZEMA ☐ ARTHRITIS ☐ ADD/ADHD ☐ SEIZURE ☐ MIGRAINES

☐ KIDNEY DISEASE/URINARY TRACT INFECTIONS ☐ HYPO/HYPERTHYROIDISM ☐ ANEMIA

☐ IRRITABLE/INFLAMMATORY BOWEL DISEASE ☐ LAZY EYE/VISION PROBLEMS

☐ HEARING PROBLEMS ☐ OTHER: _____

SOCIAL HISTORY

NUMBER OF PEOPLE IN HOUSEHOLD: _____ ANY SMOKING? Y N

NAMES & AGES OF SIBLINGS: _____

_____