

# Pediatric Patient Questionnaire

For children 12 months and older

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

INTERPRETER NEEDED?

NO  YES, \_\_\_\_\_

## a. Medications/Allergies

List any **allergy(ies)** and **reaction(s)** you have:  NONE \_\_\_\_\_

List any medications you are currently taking:  NONE

Medicine:	Dose:	How often:	3.		
1.			4.		
2.			5.		

## b. Personal Health History

Have you ever had or are you being treated for any of the following conditions?

- |                           |  |                                |  |  |  |
|---------------------------|--|--------------------------------|--|--|--|
| ADHD                      | <input type="checkbox"/> NO <input type="checkbox"/> YES | Eczema                         | <input type="checkbox"/> NO <input type="checkbox"/> YES | Depression/Anxiety                       | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| <b>Food allergies</b>     | <input type="checkbox"/> NO <input type="checkbox"/> YES | Broken or dislocated bone      | <input type="checkbox"/> NO <input type="checkbox"/> YES | Blood clots                              | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Seasonal allergies        | <input type="checkbox"/> NO <input type="checkbox"/> YES | Reflux/GERD                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | Mental illness                           | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Anemia                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | Head injury                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | <b>Learning/<br/>Developmental delay</b> | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| <b>Asthma</b>             | <input type="checkbox"/> NO <input type="checkbox"/> YES | Headaches                      | <input type="checkbox"/> NO <input type="checkbox"/> YES | Autism                                   | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Bleeding disorder         | <input type="checkbox"/> NO <input type="checkbox"/> YES | Hearing problems               | <input type="checkbox"/> NO <input type="checkbox"/> YES | Vision problems                          | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| <b>Breathing problems</b> | <input type="checkbox"/> NO <input type="checkbox"/> YES | Ear infection                  | <input type="checkbox"/> NO <input type="checkbox"/> YES | Snoring at night                         | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Concussion                | <input type="checkbox"/> NO <input type="checkbox"/> YES | Prematurity                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | Other: _____                             |  |
| <b>Heart Problems</b>     | <input type="checkbox"/> NO <input type="checkbox"/> YES | <i>How early?</i> _____        |  |  |  |
| Constipation              | <input type="checkbox"/> NO <input type="checkbox"/> YES | Seizures                       | <input type="checkbox"/> NO <input type="checkbox"/> YES |  |  |
| Diabetes                  | <input type="checkbox"/> NO <input type="checkbox"/> YES | Kidney/Urinary tract infection | <input type="checkbox"/> NO <input type="checkbox"/> YES |  |  |

### When you exercise do you have problems with:

- Passing out or feeling like you will pass out  NO  YES
- Chest pain or discomfort  NO  YES
- Heart skipping beats or racing  NO  YES
- Feeling lightheaded or more short of breath than expected  NO  YES
- Feeling more tired or short of breath than your friends  NO  YES

### Have you ever had surgery:

- To remove your tonsils and/or adenoids  NO  YES
- To remove your appendix  NO  YES
- On your teeth (dental surgery)  NO  YES
- To place ear tubes  NO  YES
- List any other type of surgeries you had:  NONE

## c. Females Only

Have you had a period?  NO  YES

If yes, what age did you start having periods? \_\_\_\_\_

Please list any problems or concerns about your periods: NONE \_\_\_\_\_

#### d. Family History

Were you adopted  NO  YES

Has anyone in your family ever had (please provide information for biological parents and siblings only).

ADD/ADHD	<input type="checkbox"/> NO <input type="checkbox"/> YES	Deafness	<input type="checkbox"/> NO <input type="checkbox"/> YES	Sudden death	<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Diabetes	<input type="checkbox"/> NO <input type="checkbox"/> YES	Sickle cell disease	<input type="checkbox"/> NO <input type="checkbox"/> YES
Cancer	<input type="checkbox"/> NO <input type="checkbox"/> YES	High cholesterol	<input type="checkbox"/> NO <input type="checkbox"/> YES	Bleeding disorder	<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart Problems	<input type="checkbox"/> NO <input type="checkbox"/> YES	Strabismus/Lazy eye	<input type="checkbox"/> NO <input type="checkbox"/> YES	Blood clots	<input type="checkbox"/> NO <input type="checkbox"/> YES

1. Has any family member or relative died of heart problems or had unexplained or unexpected sudden death before the age of 50 (including drowning, unexplained car accidents, or sudden infant death syndrome)?  NO  YES
2. Does anyone in your family have a pacemaker, implanted defibrillator, or heart rhythm problem?  NO  YES
3. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  NO  YES

#### e. Social History

Tobacco use (including vape):  NO  YES  FORMER Smokers in family:  NO  YES Smoking allowed in the home:  NO  YES

Mother's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Living:  NO  YES

Father's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Living:  NO  YES

Does child attend Daycare?  NO  YES

Primary residence:  Mother  Father  Other, \_\_\_\_\_ Secondary residence:  Mother  Father  Other, \_\_\_\_\_

Mother's occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_ # of siblings: \_\_\_\_\_

Any concerns about relationships with family/friends/other?  NO  YES

Home type:  Apartment  House  Condominium  Mobile Home (trailer)

Do you drink tap water?  NO  YES

Do you use a helmet when you ride your bike, skate, or skateboard?  NO  YES  N/A

Do you use a car seat?  NO  YES  N/A

Do you use a seat belt?  NO  YES

**Do you have the following at home:**

Carbon monoxide detector  NO  YES

Smoke detector  NO  YES

Firearms  NO  YES

How many hours per day do you spend: Playing sports/exercising? \_\_\_\_\_ Watching Television? \_\_\_\_\_ On the computer/internet? \_\_\_\_\_

#### f. Dental Health

How many times a day do you brush your teeth? \_\_\_\_\_

How many times a week do you floss your teeth? \_\_\_\_\_

Have you seen a dentist in the past year?  NO  YES

*Thank you for taking the time to tell us about your health history.*