Pediatric Associates of Julington Creek

PATIENT HISTORY QUESTIONAIRE

MOTHER'S PREGNANCY:

Age: _____ Any Problems? _____

Medication's? _____

During Pregnancy was there any:

Smoking: **Y/N** Alcohol: **Y/N** Illegal Drugs **Y/N** **I**nfections **Y/N**

Was baby:

Early: _____ On Time: _____ Late: _____? Type of delivery? _____

BIRTH:

Weight: _____ lbs _____oz Length: _____inches

APGAR Scores: _____

Problems with baby:

Breathing: _____ Jaundice: _____ Bili Lights: _____ Others: _____

FEEDING AND NUTRITION:

Colic or feeding problems within the first three months?

_____

Breast Fed: **Y / N** Number Of months: _____ Supplemented? **Y / N**

Formula: **Y / N** Current Brand: _____

Age baby food started: _____

ALLERGIES:

Medicine: _____ Animals: _____ Food: _____

IS CHILD ON MEDICATIONS? _____

IMMUNIZATIONS: Up to Date? **Y / N**

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PAST MEDICAL HISTORY:

Chronic medical problems?

_____

_____

_____

Hospitalizations?

_____

_____

_____

Surgeries/Serious Injuries? (Where-When-Why)?

_____

_____

_____

DOES YOUR CHILD HAVE OR HAD ANY OF THE FOLLOWING?

____ Asthma/Wheezing ____ Fractures ____ Freq. Ear Infections ____Urinary Infections

____ Allergies ____ Seizures ____ Chicken Pox ____ Joint Problems

____Anemia ____ Eczema ____ Bleeding Disorder ____ Blood Transfusion

PROBLEMS OR CONCERNS WITH……

Hearing _____ Vision_____ Speech_____ Development_____ Other_____

DEVELOPMENT AND BEHAIVOR:

At what age did your child:

Sit alone _____ Walk_____ Used Sentences_____ Toilet

Trained_____ Bicycled _____

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Learning Problems? **Y/N** _____

Behavioral Problems? **Y/N** _____

Bedwetting? **Y/N** Sleep Problems? **Y/N** Nail Biting? **Y/N** Smoking? **Y/N**

FAMILY PROFILE:

PARENTS: Married **Y / N** Separated **Y / N** Divorced **Y / N** Smokers **Y / N**

Father's age: _____ Highest School Grade? _____

Health? _____

Mother's age: _____ Highest School Grade? _____

Health? _____

PATIENT'S siblings (name and age):

_____

_____

_____

FAMILY MEDICAL HISTORY:

Check the box to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters, and grandparents) state your relationship in the relationship box. *F- Father, M- Mother, B- Brother, S- Sister, MF- Mother's Father, MM- Mother's Mother, FM- Father's Mother, FF- Father's Father, MS- Mother's Sister, MB- Mother's Brother, FS- Father's Sister, FB- Father's Brother.*

Asthma_____ **Allergies**_____ **Migraines**_____

Anemia_____ **Stroke**_____ **High Blood Pressure** _____

Heart Disease_____ **Cholesterol Problems**_____ **Diabetes**_____

Arthritis_____ **Drug/Alcohol Problem**_____ **SIDS**_____

Cancer (Type) _____ **AIDS**_____

Early deafness _____ **Tuberculosis**_____

Mental Retardation_____ **Epilepsy/Seizures**_____

Cystic Fibrosis_____ **Birth defects** _____ **Early Death**(less than 50) _____

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PATIENT HISTORY QUESTIONAIRE

CURRENT PHARMACY:

Preferred: _____

(Name & Location)

Phone Number: (_____) _____-_____

Alternate Pharmacy: _____

(Name & Location)

Phone Number: (_____) _____-_____

QUESTIONS/CONCERNS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____