SOUTH EAST BAY PEDIATRIC MEDICAL GROUP – HEALTH QUESTIONNAIRE

Please answer each question as best you can.

PATIENT'S NAME _____ **BIRTHDATE** _____ **SEX:** ☐ **MALE** ☐ **FEMALE**

TODAY'S DATE _____ **PERSON FILLING OUT FORM** _____

How did you hear about our practice? _____

Were you referred by your OB? ☐ **Yes** ☐ **No** **Who is your OB?** _____

BIRTH DATA

Birthplace _____

Mother's present age _____ No. pregnancies_____ No. living children _____

Father's present age _____ Are both parents living? ☐ Yes ☐ No

If deceased, cause of death _____

Check if any illnesses or complications during pregnancy:

☐ Rubella (3-day German Measles) ☐ Accident or Injury ☐ Bleeding
☐ Albumin (Protein) in Urine ☐ High Blood Pressure ☐ Sugar or Diabetes
☐ Hepatitis B Positive

Any infections or surgery during pregnancy? Explain: _____

Did mother receive medical care during pregnancy? ☐ Yes ☐ No

List any medications taken during pregnancy: _____

Any smoking during pregnancy? ☐ No ☐ Little ☐ Moderate ☐ Heavy

Any alcohol, "pot" or other drug use? ☐ No ☐ Little ☐ Moderate ☐ Heavy

Duration of pregnancy _____ months. Birth weight _____ length _____

Duration of labor _____ hours. Was labor ☐ SPONTANEOUS or ☐ INDUCED

Check any problems with delivery of patient:

☐ Breathing problem ☐ C-Section ☐ Breech (feet first) ☐ Require oxygen
☐ Require incubator ☐ Resuscitated ☐ Require intensive care, IV therapy or other,
Explain _____

During 1st month of life after birth, check if child had any:

☐ Breathing problem ☐ Fever ☐ Heart Problem ☐ Infections
☐ "Yellow" Jaundice ☐ Convulsions ☐ Blood Transfusions ☐ Antibiotics
Explain _____

FAMILY BACKGROUND

Ethnic origin: Mother _____ Father _____

Country of birth: Mother _____ Father _____

Is child adopted? ☐ Yes ☐ No Child lives with: ☐ both parents
☐ mother ☐ father ☐ other _____

Brothers/sisters – list ages and sex: _____

Any significant family history of any DISEASES, HEART TROUBLE, CANCER, INFECTIONS, BIRTH DEFECTS, or HEREDITARY DISEASES?
Explain _____

DIETARY

Was child breast fed? ☐ Yes ☐ No To what age? _____

Was child bottle fed? ☐ Yes ☐ No What formula? _____

Any allergies to foods? ☐ Yes ☐ No List _____

Does child eat NORMAL diet now? ☐ Yes ☐ No _____
If not, explain _____

GROWTH & DEVELOPMENT

Has growth and development been normal? ☐ Yes ☐ No
If not, explain _____

Give age when started: Crawling _____ (months) Sitting alone _____ (months)
Walking alone _____ (months) Talking 2-word sentences _____ (months)

IMMUNIZATIONS

Is your child UP TO DATE with shots now? ☐ Yes ☐ No ☐ Do not know

List dates or ages for LAST immunization given:

☐ MMR _____ ☐ Hepatitis B _____
☐ Measles _____ ☐ Varivax _____
☐ DPT (Tetanus) _____ ☐ Prevnar (PCV) _____
☐ Polio _____ ☐ HIB _____
☐ Other _____

ILLNESSES

Check if child has had any of the following:

☐ Measles (Regular, Hard, Red) Age _____ ☐ Mumps Age _____
☐ Rubella (3-day German Measles) Age _____ ☐ Chicken Pox Age _____
☐ Other _____ Age _____

List any SERIOUS injuries or accidents: _____

Give any ACCIDENTAL poisoning or ingestions. _____

List any hospitalizations or surgery (when, where, why, what age): _____

Any blood transfusions: ☐ Yes ☐ No Reason: _____

REVIEW OF SYSTEMS

Check if your child has had any problems with the following: EXPLAIN

☐ Growth development _____
☐ Eyes _____
☐ Ears–Nose–Throat _____
☐ Speech _____
☐ Thyroid _____
☐ Heart _____
☐ Lungs _____
☐ Stomach _____
☐ Kidneys _____
☐ Bowels _____
☐ Nervous system _____
☐ Bleeding _____
☐ Allergies _____
☐ Anemia _____
☐ Diarrhea or constipation _____
☐ Convulsions _____
☐ Eczema _____
☐ Asthma _____
☐ Hyperactivity _____
☐ Bones _____
☐ Infections _____
☐ Any allergies to drugs? List: _____

Ever worn any braces, casts, etc. ☐ Yes ☐ No Explain: _____

Other: _____

GIRLS

Have periods started? ☐ Yes ☐ No What age started? _____

Last menstrual period? _____

Any problems? _____

SCHOOL

Does child attend any school? ☐ Yes ☐ No Grade level _____

List any SPECIAL EDUCATION programs: _____

List any school problems: _____

What grades does your child get in school? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Who was your child's last doctor? _____

List any medicines your child is on now:

Use reverse side of this form for comments. Thank you.