Pediatric Associates of the Northwest, P.C.
Pediatric History Questionnaire

Today's Date: _____

Child's Name: _____ Nickname: _____ Birthdate: _____

FAMILY HISTORY:

Has your child or a family member had any of the following? If yes, check appropriate box:

Patient	Family Member	Comments
☐ Allergies	☐	
☐ Anemia	☐	
☐ Asthma	☐	
☐ Birth defect	☐	
☐ Bleeding disorders	☐	
☐ Breast problems	☐	
☐ Diabetes	☐	
☐ Drug/alcohol abuse	☐	
☐ Ear infection (How many?)	☐	
☐ Feeding problems	☐	
☐ Headaches (migraines)	☐	
☐ Heart problems	☐	
☐ Hepatitis	☐	
☐ High blood pressure	☐	
☐ HIV / AIDS	☐	
☐ Mental illness / depression	☐	
☐ Seizures (convulsions)	☐	
☐ Skin conditions (e.g., eczema)	☐	
☐ Weight problems	☐	
☐ Other	☐	

Hospitalizations (date and reason):
1.
2.

Daily Medications (include over-the-counter):		
1. Fluoride	Yes ☐	No ☐
2. Herbs	Yes ☐	No ☐
3. Vitamins	Yes ☐	No ☐
4.		
5.		
6.		
Glasses	Yes ☐	No ☐
Hearing Aid	Yes ☐	No ☐

Where has your child received previous care?**:**

_____

Has your child seen a dentist in the past year? Yes ☐ No ☐

Has your child seen an eye doctor in the past year? Yes ☐ No ☐

Has your child had alternative medical care? Yes ☐ No ☐

If yes, which alternative medical provider(s) has your child seen? _____

With whom does this child live most of the time? Both Parents ☐ Mother ☐ Father ☐ Other Relatives ☐ Foster Parent ☐

Does anyone in the home smoke? Yes ☐ No ☐

Is there a smoke alarm in the home? Yes ☐ No ☐

Are there firearms in the home? Yes ☐ No ☐

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For children up to 12 months old:

During your pregnancy with this child, did you:

Have high blood pressure? Yes ☐ No ☐

Have diabetes or sugar in your urine? Yes ☐ No ☐

Take any medications? Yes ☐ No ☐

alcohol Yes ☐ No ☐

drugs Yes ☐ No ☐

Smoke cigarettes? Yes ☐ No ☐

Deliver by C-section? Yes ☐ No ☐

Have any problems with labor or delivery? Yes ☐ No ☐

How many days did baby stay in hospital? _____

Comments: _____

_____

For children 3 years and older:

CHILD'S SCHOOL HISTORY:

Where does your child go to school? _____ What grade?_____

Has your child ever repeated or been held back a grade? Yes ☐ No ☐

Attended a special class? Yes ☐ No ☐

Any behavior problems in school? Yes ☐ No ☐

Any academic problems? Yes ☐ No ☐

If answer is "yes" to any of the above questions, please describe.

_____

_____

_____

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