

## Pediatric Health History Questionnaire:



FIRST PHYSICIANS GROUP  
of Sarasota Memorial Health Care System

Patient's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Address: \_\_\_\_\_

### Pregnancy and Birth History

Mother's age at birth:	Father's age at birth:
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#### Did mother have any of the following during pregnancy?

<input type="checkbox"/> Fever or rash	<input type="checkbox"/> Tobacco use (how much)
<input type="checkbox"/> Group B strep	<input type="checkbox"/> Alcohol use (how much)
<input type="checkbox"/> Sugar in urine / diabetes	<input type="checkbox"/> Street drug use (what type)
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Medication use (prescription or over-the-counter - list below)
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Infections (if yes what type and how were they treated)	

### Newborn History

Birth Weight:	Birth length:	Head Circumference:
Born on time? <input type="checkbox"/> Early <input type="checkbox"/> Late	How much:	
Type of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following		
<input type="checkbox"/> Feeding trouble	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fever
<input type="checkbox"/> Excess vomiting	<input type="checkbox"/> Breathing trouble	<input type="checkbox"/> Receive antibiotics
<input type="checkbox"/> Jaundice (yellow skin)	<input type="checkbox"/> Need of oxygen	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Cyanosis (blueness)	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> In intensive care unit

### Medical History

Where has child gone for check-ups previously:		
Date of last medical checkup:		
Date of last dental check-up:		
Is your child up-to-date on immunizations? <b>Please supply immunization records.</b>		
<b>Female Patients:</b> Age periods started _____ Menstrual Flow: <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/Cramps		
Has your child had any of the following		
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Asthma
<input type="checkbox"/> Measles	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Allergies
<input type="checkbox"/> Mumps	<input type="checkbox"/> Kidney or bladder infection	<input type="checkbox"/> Broken bones
<input type="checkbox"/> Frequent ear infections (>4 year)	<input type="checkbox"/> Bed wetting (>5 years old)	<input type="checkbox"/> Head injury
<input type="checkbox"/> Frequent throat infections (>4 year)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
Has your child ever been hospitalized or had surgery? If yes, list age and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Have any of the child's relatives had the following conditions:			
Condition	Relative	Condition	Relative
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney problems	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Seizures		<input type="checkbox"/> Skin problems	
<input type="checkbox"/> Allergies/asthma		<input type="checkbox"/> Anemia	
<input type="checkbox"/> Bleeding problems		<input type="checkbox"/> HIV	
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Chemical dependency	
<input type="checkbox"/> Mental illness		<input type="checkbox"/> Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

Allergies:	
Please list any allergies to medications or foods	
Name	Symptom/Reaction

Medications:					
Please list any medications that your child takes including over the counter medications, herbs, and supplements.					
Name	Dose	Freq.	Name	Dose	Freq.

Specialty Providers:	
In order that we can best coordinate your child’s care, please list any medical providers they see outside of this practice	
Name: _____ Phone: _____ Last Seen: _____	Name: _____ Phone: _____ Last Seen: _____
Name: _____ Phone: _____ Last Seen: _____	Name: _____ Phone: _____ Last Seen: _____