UCLA Health

MRN:
Patient Name:

(Patient Label)

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Home Phone: _____

Parent / Guardian:

Mother: _____

Father: _____

Other: _____

Members of Household: _____

_____

_____

_____

Medication: _____

_____

_____

Allergies: _____

_____

_____

Past Medical History: _____

Any complications as a newborn or during prenatal care? ☐ Yes ☐ No

Any developmental delays? ☐ Yes ☐ No

Any hospitalizations? ☐ Yes ☐ No

Emergency room visits? ☐ Yes ☐ No

Any History of:

1. Chicken Pox ☐ Yes ☐ No
2. Measles ☐ Yes ☐ No
3. Seizures ☐ Yes ☐ No
4. Urinary Tract infections ☐ Yes ☐ No
5. Asthma ☐ Yes ☐ No
6. Heart Problems ☐ Yes ☐ No

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Family History	Age	Health Problems
Father:		
Mother:		
Siblings:		
Grandparents:		

Any smokers in the household? ☐ Yes ☐ No

Any guns in the home? ☐ Yes ☐ No

What school does child attend? _____

Are there any concerns of school related problems: _____

_____

_____

What grade is child in? _____

What activities? (sports / hobbies) _____

Any special concerns? _____

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____

Physician Signature _____ ID # _____ Date _____ Time _____