HOLLAND COMMUNITY Health CENTER

Pediatric Patient Questionnaire

Patient: _____ Date of Birth.: _____

Pregnancy and Birth

Mother's age at pregnancy _____ Any illness during pregnancy? _____

Medications during pregnancy? _____

Did you smoke, drink alcohol, or use illegal street drugs during your pregnancy? _____

Weeks of gestation: _____ Place of birth: _____

Type of delivery: _____ Birth weight: _____ lbs _____ oz Length: _____ inches

Were there any complications during delivery? _____

Problems with infant at birth? _____

Were there any breathing problems at birth? _____ Jaundice at birth? ☐Yes ☐No

Other problems? _____

Were there any problems in the nursery or at home? _____

Past Medical History

List allergies: _____

Medications taken on a regular basis: _____

Immunizations up to date? ☐Yes ☐No Do you have record? ☐Yes ☐No

Hospitalizations: when, where, why:

1. _____
2. _____
3. _____

Serious Injuries: when, where

1. _____
2. _____
3. _____

Has your child had any of the following (please check those that apply):

☐ Red Measles	☐ Anemia	☐ Ear Infections	☐ German Measles	☐ Vision Problems
☐ Chicken Pox	☐ Bleeding tendency	☐ Eczema	☐ Rheumatic Fever	☐ Joint Problems
☐ Scarlet Fever	☐ Blood transfusions	☐ Hives	☐ Strep Throat	☐ Mumps
☐ Asthma	☐ Mumps	☐ Hepatitis	☐ Seizures	
☐ Wheezing	☐ Whooping Cough	☐ Urinary Infections	☐ Hearing Problems	

☐ Other: _____

Feeding and Nutrition

Any know food allergies? _____

Appetite usually good? ☐Yes ☐No

Colic or feeding problems during the first three months of age? ☐Yes ☐No

Breast fed? ☐Yes ☐No Number of months: _____ Formula? ☐Yes ☐No Current brand: _____

Vitamins? ☐Yes ☐No Brand_____ Special Diet? ☐Yes ☐No Explain: _____

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Family Profile

Parent(s)/Guardian(s)

Parent/Guardian Age: _____ Highest Level of Education: _____ Parent/Guardian Health: _____

Parent/Guardian Age: _____ Highest Level of Education: _____ Parent/Guardian Health: _____

Siblings:	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Name	_____	_____	_____	_____
Age	_____	_____	_____	_____

Additional Siblings: _____

Family Medical History

List all blood relatives of your child who have had the following problems. Use abbreviations (F) father (M) mother (B) brother (S) sister (MM) mother's mother (MF) mother's father (FM) father's mother (FF) father's father (A) aunt(U) uncle (C) cousin

Anemia / Blood Disorders: _____ Asthma: _____

Mental Retardation: _____ Drug Problem: _____

Alcoholism: _____ Cancer: _____

Aids: _____ Cystic Fibrosis: _____

Muscular Dystrophy: _____ Tuberculosis: _____

Arthritis: _____ Epilepsy / Seizures: _____

Heart Disease: _____ High Blood Pressure: _____

Cholesterol Problem: _____ Migraines: _____

Sudden Infant Death: _____ Birth Defects: _____

Early Deafness: _____ Diabetes: _____

Development and Behavior

Please indicate the age at which your child:

Sat Alone: _____ Walked: _____ Used Sentences: _____ Toilet Trained: _____ Bicycled: _____

Your child's development compared to other children:

Your child's current grade in school: _____

Does your child have problems in school? ☐Yes ☐No Explain: _____

Does your child have learning problems? ☐Yes ☐No Explain: _____

Does your child get along with other children? ☐Yes ☐No Explain: _____

Does your child have behavior problems? ☐Yes ☐No Explain: _____

Does your child have any bad habits? ☐Yes ☐No Explain: _____

Does your child wet the bed? ☐Yes ☐No Explain: _____

Does your child bite his/her nails? ☐Yes ☐No Explain: _____

Does your child have trouble sleeping? ☐Yes ☐No Explain: _____

Does your child have any hobbies / play sports? ☐Yes ☐No Explain: _____

Does your child use street or illegal drugs? ☐Yes ☐No Explain: _____

Anything else that you would like us to know about your child: _____